the MODERN HOSPITAL

VOLUME 60 APRIL 1943 NUMBER 4

MARCHING ALONG TOGETHER

IT IS a source of great satisfaction that in this emergency, our country has come to rely upon the Sklar Company for a substantial portion of its surgical instrument requirements.

The award of the Army-Navy "E," first on August 10, 1942 and again on February 6, 1943, is evidence of an accomplishment for our Government and all the United Nations—for our instruments are now in all parts of the world—wherever soldiers of the United Nations are serving.

But amid all this tremendous demand, Sklar has not forgotten the civilian needs. The supply is restricted, to be sure, but we are doing the best we can to supply absolutely essential equipment. You cannot count on immediate shipment of all that you may need, so our earnest advice is to protect, conserve and preserve the instruments you now have. They may have to last for the duration.

There'll be plenty of Sklar instruments and apparatus immediately after V-Day. In the meantime, we're all marching along together for Victory.

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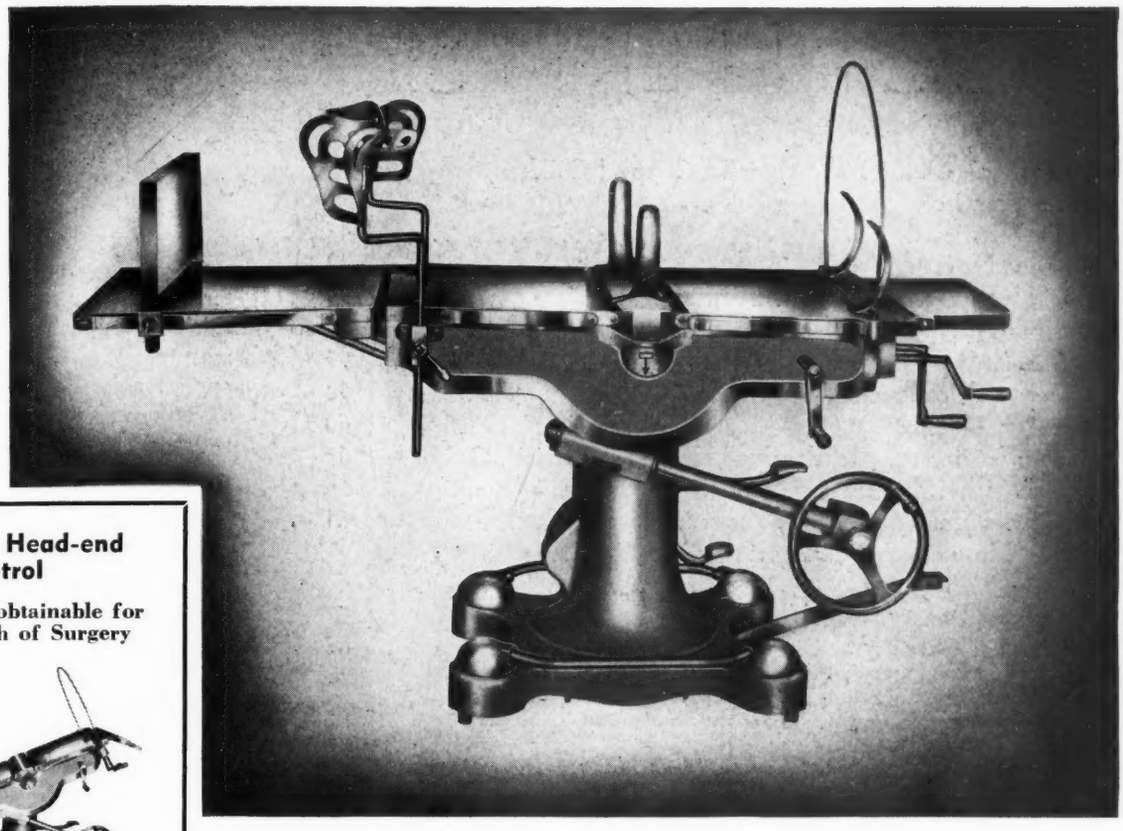

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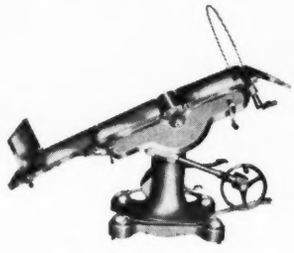

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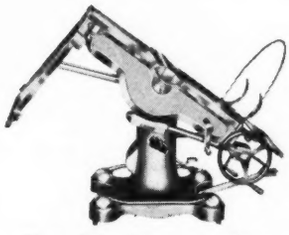

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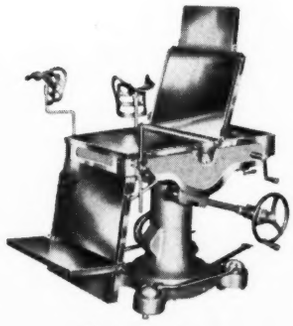

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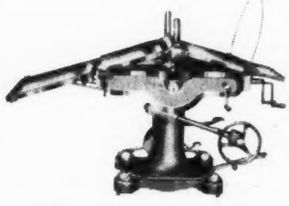

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Simplicity and flexibility have been combined to a remarkable degree in the Hartley Operating Table. Twelve different surgical positions are obtainable, with head-end control by the anesthetist. Four of these positions are shown in left panel. Precision manufacture, an efficient hydraulic lift, machine cut gears and the free use of ball bearings make for ease of control, rigidity and perfect balance at all times. All mechanism is enclosed yet readily accessible. Accessories for all surgical procedures are available.

The Hartley Operating Table includes every tested feature proven desirable and sound by the profession. It provides unusual convenience for the surgeon and maximum comfort for the patient. Its excellence of design, completeness of equipment and high quality make Hartley the finest general operating table this company has produced in its 44 years of experience as builders of operating tables.

Write for general descriptive bulletin giving complete specifications.

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CONTENTS

Just in Passing—

ISN'T it just an editor's luck to have paper rationing coincide with the biggest news boom of the century? With 50 to 75 news stories appearing in each issue, we find ourselves publishing a magazine within a magazine.

By last autumn our news coverage had become so expansive that some readers were missing items vital to their institutions. To aid them we inaugurated in December a page called "Headlines," which gave the reader a quick skimming of the cream of the month's events. This proved successful.

BUT the tide of significant news, much of it from Washington, has become a flood. So we take the next step. Beginning with this issue, four of the best pages in the book editorially speaking—the four immediately following "Looking Forward"—will contain "Headline News." The stories on these pages may emanate from Washington, Miami or London but they are stories that alert hospital administrators won't ever want to miss.

THE wise ones won't overlook the rest of the news, either, which will appear in its accustomed position in the major section following "Hospital Medicine and Pharmacy." We are striving to sift all chaff from the news, giving only the significant kernels; we must, at all costs, maintain intact the main body of the magazine.

ALTHOUGH, like other publishers, we bow to W.P.B. rules on paper rationing, there will be no diminution in the quality or comprehensiveness of the coverage.

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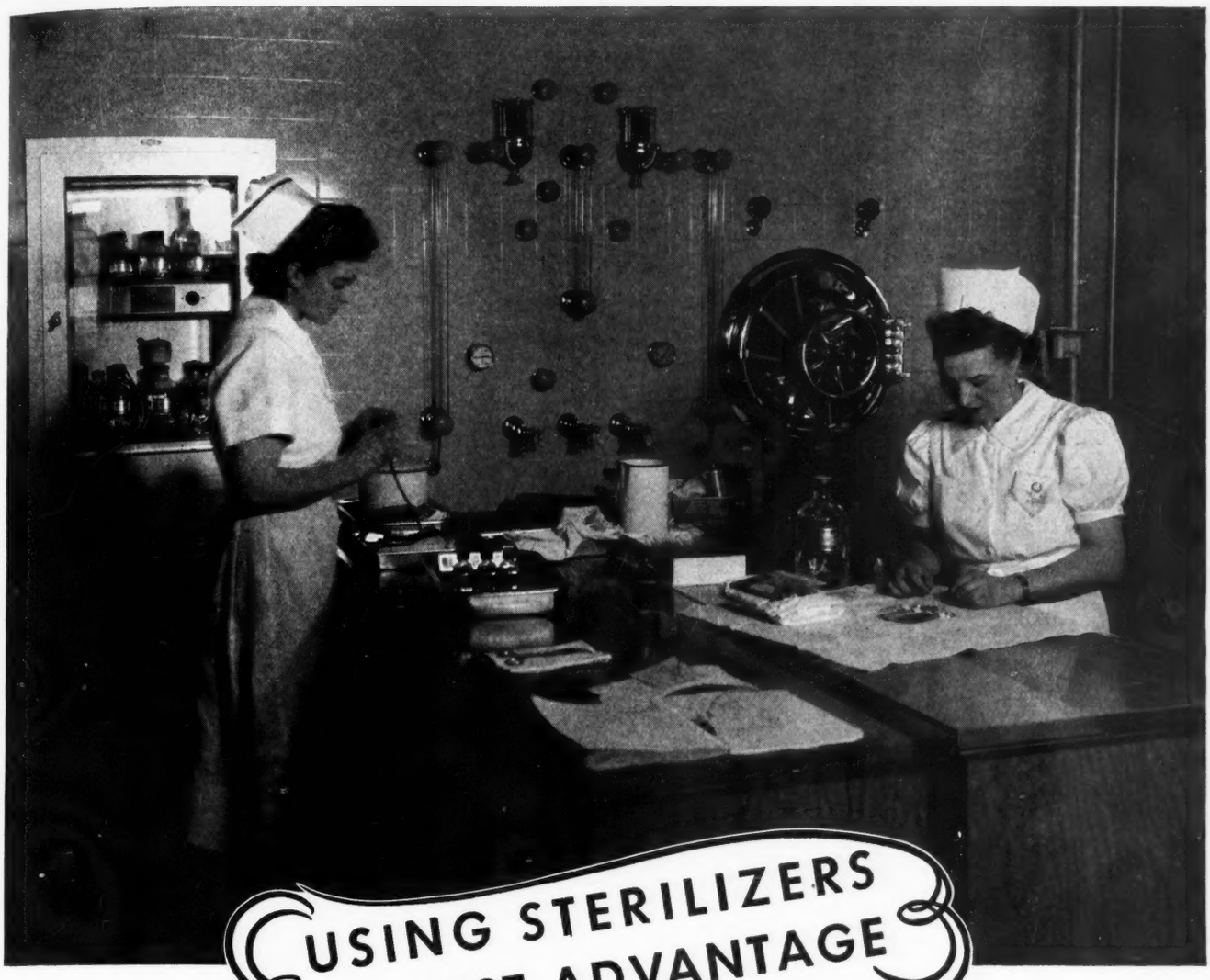

USING STERILIZERS TO BEST ADVANTAGE

Above: A modern central service room at St. Joseph's Hospital, Elgin, Illinois.

Since wartime conditions limit the supplying of new sterilizers to civilian hospitals, obviously the best solution for the present is to utilize to best advantage the existing equipment in the hospital. In this connection, the advantages of a central sterilizing and supply room in the hospital are forcefully emphasized.

Centralization results in marked economy of materials, supplies, equipment, personnel, and supervision. Autoclaves, technical equipment, and supplies can be grouped in one location under centralized responsibility and will serve all departments and floors of the hospital, giving full time use when necessary.

Our engineering and planning department will gladly assist in arranging for central service or other facilities to expedite hospital work under today's difficult circumstances.

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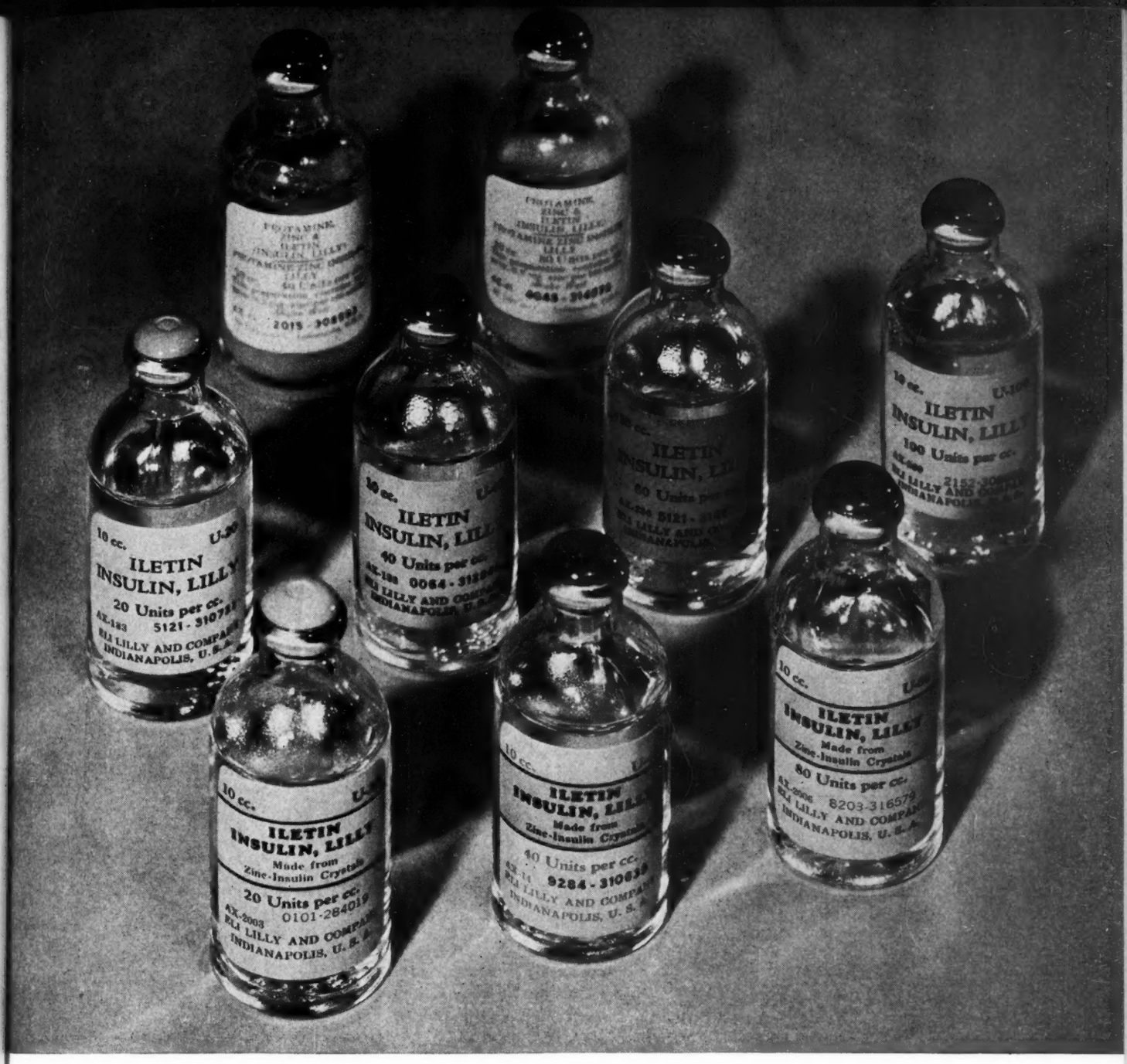

AFTER TWENTY YEARS

Iletin (Insulin, Lilly) has passed its twentieth milestone of satisfactory performance as a therapeutic agent. It was first offered to the medical profession in 1923. Acclaimed by physician and patient alike, its value in the management of diabetes long has been established. Iletin (Insulin, Lilly) in its various strengths and package sizes, together with its modifications, should be available in every hospital pharmacy and prescription room.

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THE ROVING REPORTER

For Blood Bankers Only

Now that almost every sizable hospital has a blood bank either in operation or in contemplation, a by-product of the bank, bearing great significance to the public health, should not be overlooked.

What is being done to inform, educate and treat those donors whose 500 cc. of blood goes down the drain because the Kahn or Wassermann test is positive?

The answer, alas, is "Too little." A questionnaire study of this subject is reported in a recent issue of the *Journal* of the American Medical Association and it is appalling to find how many hospitals do not inform the donor of the test findings so that he can be retested and, if the earlier result is verified, get the necessary information to protect his family and others and the essential treatment for the disease.

Some hospitals report these positive reactions to the local board of health but the individual who is diseased is left in ignorance.

The A.M.A. recommends that the reporting of positive reactions to tests for syphilis to the volunteer blood donor be assigned to one staff member.

How many hospitals take blood from their own personnel? Children's Memorial Hospital, Chicago, proudly reports that the names of 89 employes appear on its volunteer blood donor list.

Cause for Applause

Every now and then—only not often enough—some hospital or organization comes out with a really original idea in annual reports.

Congratulations to Mrs. Mildred Smith, executive secretary of the St. Louis Society for Crippled Children, for her recent brain child "The ABC's of 1942." It would not be suitable, perhaps, for imitation by a large general hospital but for a children's institution the idea belongs in Class I A. Of course, it has to be cleverly executed and Mrs. Smith is a lady that can execute an idea in sparkling fashion.

An eight page lithographed job, the report has the ABC rhymes in red ink at the left of the page with prose comments in black ink pulled over to the right so as to give plenty of "white space" for relief. Let's take a few "tough" letters to see how the scheme is worked out.

Q stands for Quest
For the proper resource
For every child needs
Special treatment, of course

Casework service was given on each of the 228 cases served during 1942. Each child's needs were individually fulfilled.

U stands for Urgent
Appeals for assistance
Received from homes, schools
And clinics, for instance.

Of the new cases of children referred to the Society in 1942,
41% came from schools,
37% from medical centers and physicians,
11% from other social agencies, and
11% from the patient, family or other closely related individuals.

The final page of the book contains a financial report, much simplified for public consumption, and the back cover lists the board of directors of the society.

For Large Hospitals Only

Since one large mental disease hospital established four first-aid stations at central points in the general wards, it has solved a perennial problem.

Formerly first-aid work and minor medications were handled in the oper-

WAR ADDS TO HOSPITAL LOAD ...services must be maintained

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ating room. This practice has three big disadvantages: (1) it takes an enormous amount of employes' time to transfer patients to the general hospital; (2) there was considerable delay in the treatment of injuries, and (3) the operating staff was deluged with routine work.

Florida State Hospital at Chattahoochee is the institution that has thus decentralized first-aid and minor medications work. To these newly established first-aid stations three full-time graduate nurses are assigned to administer treatments and dressings for lacerations, abrasions, ulcers, eruptions and other minor local conditions. These treatments often run as high as 16,000 a month, so you can see what a drain on the operating room they were. J. H. Therrell, the administrator, is well pleased with the new arrangement.

For Up-to-Date Magazines

Do your patients grumble about the age and weakened physical condition of the magazines that the hospital's friends and neighbors send in?

If so, perhaps the administrator can do a little reeducating of these well-intentioned donors. Through your hospital bulletin or women's auxiliary, through the acknowledgment routinely made of such gifts and through a variety of other contacts with the friendly public people can be taught not to wait for housecleaning time to rid themselves of a year's or half year's accumulation of good reading matter. The patients would like to have the magazines while some of the crisp newness is still on them.

Jacob Goodfriend, assistant administrator of Montefiore Hospital, New York, sums up the situation thus:

"If those who have adopted the generous habit of sending reading matter to hospitals would only send it soon after they are through reading it, even though the quantity is small, it would serve the intentions of the donors to far better advantage."

Clergy Is Welcomed

Patients in Hamot Hospital, Erie, Pa., are assured visitations from the clergy if they desire them. What appears to be a particularly successful plan has been worked out by Donald M. Rosenberger, director. It centers upon a card or information blank for hospital visitation on which such details as the name of the patient, home address, church affiliation, church preference, location in hospital and date admitted are filled out by the admitting officer.

These cards are checked each day by a member of the Erie Council of Churches and respective pastors are notified. Patients from out of town and those who have no church affiliation but who wish spiritual guidance are attended by a visitation committee comprising four members.

The clergy is much pleased with this handling of the matter, Mr. Rosenberger reports. This goes for the patients as well.

Flags for Physicians

Those staff doctors of yours who are now in New Guinea or Tunisia or are sailing the seven seas need more individual recognition than the star in your hospital service flag, some of you may be thinking.

Sister M. Patricia, O.S.B., has a suggestion for you. Beside the name of every physician who is active in the armed services and, in consequence, inactive on the doctors' register in the home hospital, St. Mary's Hospital, Duluth, Minn., places a tiny U. S. flag.

"Such a practice," Sister M. Patricia suggests, "not only honors the absent but serves as a constant reminder to the public that hospitals and the medical profession are playing an important part in the war effort.

"Best of all, the men who come home to visit like it," the administrator at St. Mary's declares.

For the First Time—

SULFATHIAZOLE *IN A READY-MADE DRESSING*

Curity SULFA-thia-zole HANDI-TAPE is the first ready-made dressing to contain one of the sulfa-compounds. The gauze pad is impregnated with sulfathiazole which is released on contact with the moist wound surface.

Careful study in the Bauer & Black Laboratories has now combined the *proved* simplicity of familiar HANDI-TAPE with the *proved* efficacy of sulfathiazole . . . the result is a distinct improvement in the protective value of ready-made dressings. Curity SULFA-thia-zole HANDI-TAPE—readily identifiable by the yellow gauze pad—is now ready, in large, economical packages at your surgical supply dealer's—and from your BAUER & BLACK representative.

This is the package now available at drugstores for first aid protection at home.

Not for sale in Arizona, Connecticut, Minnesota, and Utah.

BAUER & BLACK

Division of The Kendall Company • Chicago

Curity
REG. U.S. PAT. OFF.

Curity SULFA-thia-zole HANDI-TAPE is ideal for use in the hospital out-patient department and for first aid protection of hospital personnel. For these uses, two sizes of HANDI-TAPE, medium (1" x 3⅜") and small (¾" x 3") are packed in economical cartons of 100 HANDI-TAPES . . . each individually wrapped, then sterilized after packaging.

READER OPINION

Push for Decent Wages!

Sirs:

The subject of decent living wages for hospital employes is not just an outgrowth of manpower shortages caused by the war situation but is a disgraceful situation that has existed in our hospitals for far too many years. The time has come when the general taxpaying public, through its city and county, state and national elected representatives, must stop exploiting hospital employes.

Just as soon as each community assumes the proper responsibility of paying a reasonable rate for the care of not only the categorical indigents but also the medical indigents, as defined in the New York State Welfare Law in our voluntary hospitals, we will have sufficient funds to pay at least decent living wages.

I see no possibility without tremendous government subsidy of ever competing with the abnormal wage levels existing in industry and business today. Boards of governors and trustees of hospitals have for too long failed to accept the same responsibility to hospital employes that they have always assumed toward employes in their own business and industrial enterprises.

I just can't believe that any community will let its voluntary hospitals go bankrupt because of insufficient funds to pay reasonable living wages to hospital employes. It seems to me that it is high time that some responsible organization, probably the American Hospital Association, should assume some really aggressive and constructive leadership in this vital problem. The very life of our institutions depends on such leadership.

Everett W. Jones
Head Hospital Consultant
War Production Board
Washington, D. C.

Local Rehabilitation Vital

Sirs:

Correction of remediable defects brought to light by draft boards is important not only from the standpoint of national defense but also as far as the welfare of communities is concerned.

It will be unfortunate if communities do not take advantage of the health inventory taken at federal expense of the male population falling in the draft age. Many of these defects, if left unchecked, may lead sooner or later to complete disability. Thus, instead of becoming self-sustaining citizens, boys may turn into chronic invalids incapable of earning their living and will become a burden on their community. Such a trend of events must be prevented by all available means. Our existing health agencies, among them our hospitals, must cooperate in such prevention.

Official figures thus far published do not represent a true picture of the existing situation. By the very nature of their work draft board physicians are chiefly concerned in protecting the armed forces from the liability of enlisting individuals who may become disabled. In their efforts to accomplish this purpose doctors are bound to reject many who, under civilian standards, would never be considered disabled. In many instances the suspicion of the possibility of the presence of a disease suffices for the rejection of a draftee. Therefore, the number of cases in need of rehabilitation will be considerably lower than it would seem from the statistics published.

The program of rehabilitation, obviously, will have to be conducted through local channels and, if need be, assisted by federal resources. In such an undertaking our hospitals, particularly their out-patient departments, will have to take a leading rôle.

In disease prevention, however, time is an essential factor. Defects that could be remedied today with slight effort may become irremediable disabilities tomorrow.

M. Pollak, M.D.
Medical Director and Superintendent
Municipal Tuberculosis Sanitarium
Peoria, Ill.

My Modest Opinion

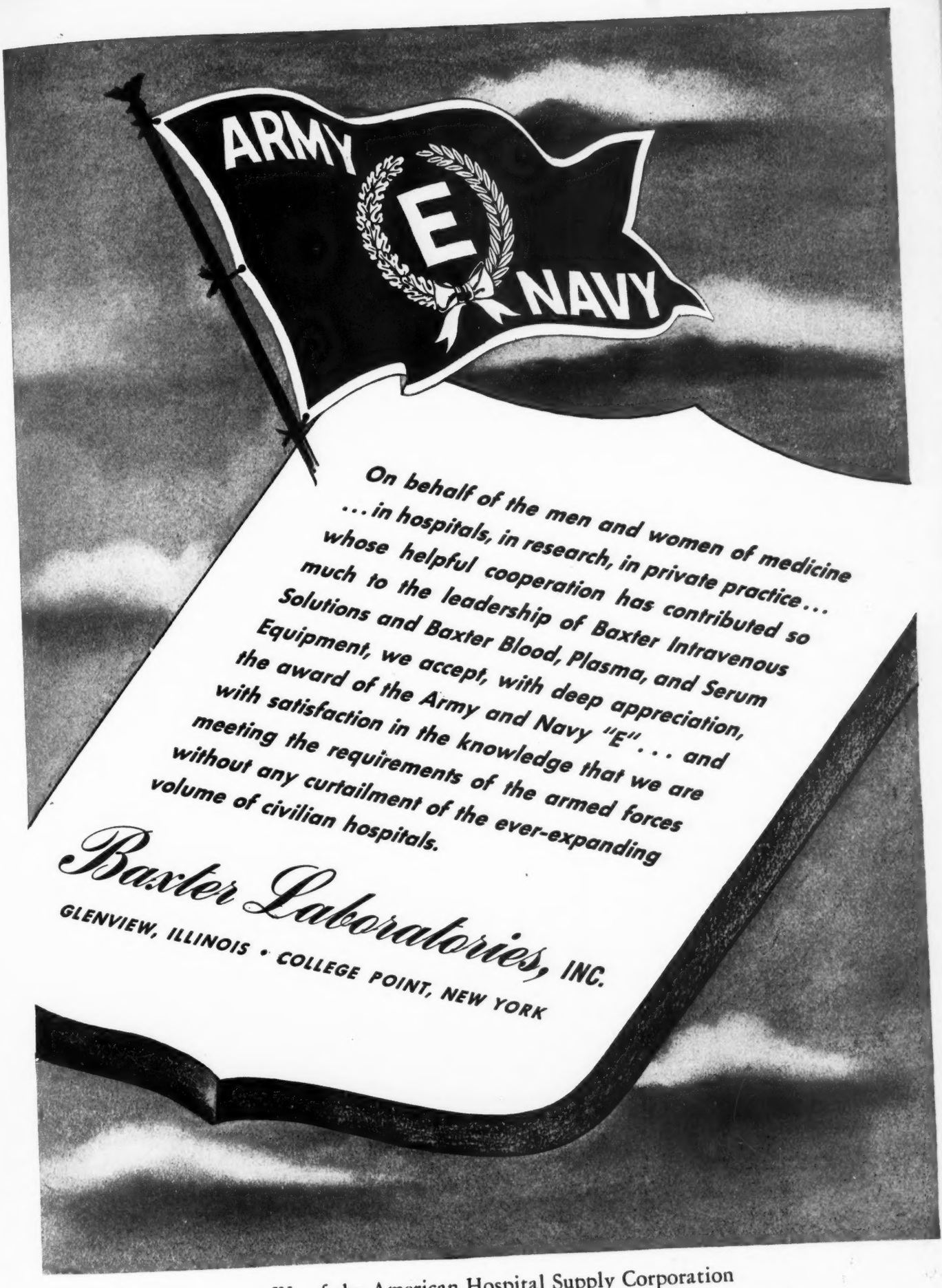
Sirs:

Some time ago, through the kindness of a doctor friend, I had the great pleasure of looking over the splendid book, *El Libro del Hospital Moderno,* that under your expert supervision was published by The Modern Hospital.

In my capacity as professor of architectural composition of the School of Architecture of the National University of this territory, I take pleasure in giving you my modest opinion on that interesting publication. The judgment shown in its editing, its clear and accurate conceptions, the theoretical-practical exposition of the organization and internal mechanism of the different kinds of medical service, the statistical data and, finally, all those characteristic and fundamental aspects from which the student can obtain clear vision present a complete panorama of whatever may concern hospital architecture.

I would appreciate it if you would inform me regarding the appearance of the next edition.

Guido A. LoVoi
Rosario, Pcia Santa Fé
Argentina



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SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

Perpetual Inventory on Priorities

Question: What is a good way for a small hospital to keep an inventory on necessary priority items, not involving too much book work, yet showing replacement time of items? —L.R., Ill.

ANSWER: I suggest that perpetual inventory records be maintained in connection with priority items. The perpetual inventory card should provide space for description of the item, name of vendor, date and quantity received, cost per unit, date and quantity issued and balance of quantity on hand. The card should also provide space for the maximum quantity and minimum quantity that should be on hand.

In order to reduce the bookkeeping to a minimum, I suggest that wherever possible the records be maintained in case lots. In other words, when a case is broken, it should be recorded on the card by means of a stores requisition. In the event that the floor or department is requisitioning in less than case lots, the unused portion of the supplies, wherever practicable, should be set aside for the particular department or floor.—ROBERT PENN.

Salary for Nurses' Aides

Question: What is the average salary being paid to nurses' aides?—W.E.A., Ill.

ANSWER: From $40 to $50 per month and one or more meals per day would seem to cover the average salary paid to the nurses' aides who are not volunteers. —A. F. BRANTON, M.D.

Retaining Notes on Patient's Chart

Question: How long should nurses' notes be kept on the patient's chart?—A.H.P., Va.

ANSWER: The meaning of this question is not entirely clear. If the questioner means while the patient is in the hospital, nurses' notes should be kept during the entire period of hospitalization to guard against any questions that may arise after the patient has been discharged.

After the patient has been discharged, nurses' notes should be kept indefinitely as they often include pertinent information on the patient's treatment and course that has not been recorded elsewhere in the medical record.—MALCOLM T. MACEACHERN, M.D.

Permanent File for Patient's Record

Question: Our patients' records are kept indefinitely. What is the legal time?—M.F.B., Ont.

ANSWER: There is no time fixed by law for the keeping of a patient's record. However, the original chart should be kept indefinitely, if possible, or in some modified form for legal purposes. Records of adults may be needed during the six year statute of limitations for the collection of hospital bills or to defend the hospital or its personnel against a malpractice or negligence suit during the two or three year statute of limitations.

In the case of children, the statute of limitations for the bringing of negligence actions may not begin to run until the child has reached the age of twenty-one years; it may, therefore, be desirable to retain the chart until at least that age is reached. There are other legal uses for the record, such as proving age, parentage and citizenship, particularly during war time when persons seek defense jobs or are being inducted into the armed forces. It is difficult to predict all of the legal, medical or research purposes for which a chart may be required and the general policy should be to preserve the record as long as possible.—EMANUEL HAYT.

Four Nurses for 16 Beds

Question: How many nurses are needed to care for patients in a 16 bed hospital? What salaries should be paid?—K.F.C., Ohio.

ANSWER: Basing my opinion on the hospital at capacity I would say that three nurses for days and one at night would be sufficient. One day nurse should be on call for emergency work at night.

Salaries would run from $75 to $90 and full maintenance.—A. F. BRANTON, M.D.

Rules for Emergency Action

Question: Is there a small book or pamphlet drawn up by a hospital with simple rules for action in cases of emergency? We are organizing a group for use in an emergency with chief engineer in charge of stretchers; he will appoint the assistants on the various floors and assign their duties. Our city fire chief gave the first talk and demonstration.—M.F.B., Ont.

ANSWER: Organization of a hospital to meet an emergency involves the development and proper organization of the medical staff, the employed force and the volunteer corps. These groups should then be trained in their particular duties.

It is necessary, of course, to have all casualties admitted through one door and to have one doctor in charge at the casualty receiving door to classify patients properly. Record workers and stretcher bearers are necessary at this point to convey the patients to the proper department of the hospital and to see that the paper work is properly cared for.

In the civilian defense medical division setup it has been arranged for hospitals to have an exchange plan for facilities, such as stretchers and blankets, so that the patient can stay on his own stretcher from the point where he is picked up on the field until the time when he is finally put in his bed in the hospital. This exchange plan necessitates the assignment of one responsible hospital employe to the duty of supplying ambulances with replacement equipment. Each hospital must develop its plans to suit the physical and personnel limitations of the particular hospital.—OLIVER G. PRATT.

Hospital Discounts for Clergy

Question: Are courtesy discounts given the clergy in nonchurch hospitals for themselves and family; if so, what discount?—A.H.P., Va.

ANSWER: Courtesy discounts vary in many sections of the country. The usual discount adopted is 20 per cent if it is allowed at all. While nonchurch hospitals generally do not consider a discount to the clergy, there are, however, many hospitals in smaller communities that consider it desirable to give concessions to the clergy. The discounts vary from 20 per cent to entirely free service.

I would believe it to be an individual problem for each hospital to consider.—CHARLES A. WORDELL.

Service for Free Care

Question: How long should an employe in the laundry or kitchen be on the payroll of the hospital before he is entitled to free hospitalization?—R.E.F., N.B.

ANSWER: There is no uniformity in this procedure, particularly in these days of rapid turnover of personnel. In many hospitals this type of patient comes under the Hospital Act of the Province and the account is paid at statutory rates. A suggested regulation would read, "No free hospitalization for less than six months' service unless caused by a condition arising out of the employment."

Length of hospitalization after six months should be in direct ratio with the length of service in the institution; for example, one week's hospital care for each year of service up to three years. Any periods over this should be dealt with individually as the occasion arises. —GEORGE F. STEPHENS, M.D.

LOOKING FORWARD

Getting Out of the Cellar

THE time has come for hospital administrators and trustees to face realistically with the public and with governmental officials the true situation on employes' salaries. As Everett W. Jones points out in a letter in this month's Reader Opinion column, hospitals have won for themselves the dubious reputation of being employers who "exploit" their help.

This situation is not due to any innate perversity on the part of hospital administrators or trustees. The former would find life much easier if they could pay "going rates." The latter give their time, energy and, so far as they can, their private fortunes to the advancement of the institutions with which they have become allied. Low hospital salaries probably do not result from any single cause unless, perchance, it is the hold that habit and tradition have on a field that is customarily thinking in terms of human welfare rather than in the terms of the market place.

The nefarious results of a low-wage and low-salary policy are everywhere all too apparent. Hospital organizations have been decimated or worse with high labor turnover. Today many institutions are almost denuded of young vigorous employes and are overloaded with physically and mentally handicapped workers—some, it is true, doing an excellent job in spite of disabilities but others holding back the institution from the attainment of the type of service which the public has a right to expect.

Henry Ford has taught large segments of American industry the economy of high wages. In his hospital, for example, no one receives less than $5 per day; this was true right through the depression. Others may not wish to follow his path in this regard but we all can well study his experience and adopt those elements that are of value to us.

Higher wage and salary schedules probably will increase somewhat the cost per patient day, although there are many able administrators who declare that this increase will be only slight inasmuch as the output per person can and should rise markedly and labor turnover should decrease. Let us suppose that higher pay scales do increase cost. How is the increase to be met?

First, every reasonable economy should be practiced. In a recent article in this magazine (August 1942, p. 51) 21 steps for reducing nursing costs without impairing service were outlined. Other issues have been full of similar material.

Second, rates may have to be increased, especially to any groups that are able to pay but are now obtaining service at less than cost. These include particularly commercial insurance companies, state, county and city governments and similar groups. Blue Cross plans in many areas have already shown themselves ready and willing to pay higher rates when these are justified.

Third, we can appeal to the public to help us by increased contributions. The public's own safety is threatened if hospital care becomes too dilute.

Obviously, our salaries cannot compete with those of war industries, but we should be able and ready to pay our employes the going rates in our communities for similar work under similar conditions in all fields of activity except the war industries. Such a procedure, in the long run, is good for patients, for the contributing public, for governmental agencies and for employes. Furthermore, it will help hospital administrators and trustees to increase their own self-respect.

Elastic Capacity

HOSPITAL overcrowding has become acute in some communities, so acute indeed that in a few places the Blue Cross plans have unfortunately been ordered to stop all enrollment of new subscribers. In many communities the problem has been intensified

because hospitals have had to close certain sections owing to lack of nurses and other personnel. If we must provide care for perhaps a million of our soldiers, sailors and marines, as recently predicted by Maury Maverick, the problem will be greatly intensified.

Before we publicly confess our inability to meet community and national needs, every possible method of expanding service should be fully utilized. If the length of stay of patients in a 200 bed hospital has been averaging ten days and can be cut to eight, that step alone is the equivalent of giving the hospital an increase of 50 beds and the personnel to serve them. For normal obstetric and surgical cases, four, five and six day stays are being used in various hospitals. Unquestionably there are dangers. But the final decision ought to rest on the greatest good to the greatest number.

Hospitals may also be able to curtail substantially the diagnostic service they have been rendering. This has been done by the Cleveland hospitals and has freed both beds and personnel for the care of more acutely ill patients.

Sun porches, lounges, waiting rooms, recovery rooms and similar spaces can often be converted for patient occupancy. With a little ingenuity, many single rooms can be used for two patients. Space can also be taken temporarily from other departments to provide needed hospital expansion.

As hospitals push up toward 100 per cent occupancy, admissions may be screened more carefully and only those of an emergency nature accepted.

Admittedly, none of these expedients is desirable. But they are all preferable to the suggested alternative of putting the Blue Cross plans "on ice" and preventing their proper expansion during this critical period. Any crowding that may result from Blue Cross plans is a mere bagatelle compared to the crowding that would result if the Social Security Board plan were inaugurated.

Sit and Wait

THE hospital service plans are setting their own houses in order so that they can carry out the mandate of the American Hospital Association house of delegates at St. Louis. This mandate directed them, in effect, to accelerate enrollment and spread it widely to reach the entire self-supporting population of the United States as soon as possible.

Plans alone can go only so far. As Dr. R. H. Bishop warned the midwinter hospital conference, the weakness now is that there is not enough support and intelligent backing by the hospitals. Every hospital should now throw its support vigorously behind the A.H.A. approval program and behind the efforts of its local plan to accelerate enrollment. This is a time for the warmest cooperation between plans and hospitals. Yet even now, when the very existence of Blue Cross plans and probably of voluntary hospitals themselves is threatened by a vast expansion of governmental function, some hospitals are so narrow, selfish or blind that they refuse to cooperate wholeheartedly with their own offspring. In one state, in fact, there is no Blue Cross plan today because of the opposition of a large church hospital.

Fortunately, most hospitals have worked strongly to help the plans and many are today redoubling their efforts. Both in speech and in action, the house of delegates, the presidents and secretaries of state and regional associations and the national officers and committee chairmen of the plans, as well as of the A.H.A., have shown a determination to carry forward vigorously the program laid out at the St. Louis convention. This is the best hope for the future of voluntary hospitals in America.

Accounting Again

A RECENT survey conducted by this magazine of the accounting practices of a group of small hospitals revealed a surprising and disappointing lack of common practice. Up to the present, perhaps, this has been a matter that concerned only the individual hospital. Now, however, it is taking on a wider significance.

Increasingly, state and local welfare departments, insurance companies, Blue Cross plans, charitable organizations and others are being asked by hospital associations to pay them on a cost basis. This is altogether right and proper. But what is "cost"? We defy anyone to explain it on the basis of the average hospital's accounting system.

The A.H.A. manual entitled "Hospital Accounting and Statistics" offers such a simple straightforward system of financial record keeping that it seems almost incredible that so many hospitals disregard it. In the most recent edition special chapters have been added to make the system readily adaptable to the needs and abilities of even the smallest hospitals.

When a Blue Cross plan goes to the state insurance commissioner to ask for the right to pay a higher rate to hospitals because their costs have increased, the commissioner, if he is alert to his responsibilities, may quite properly ask for evidence to show such an increase. If as evidence he receives financial statements that reflect merely the arbitrary ideas of an inexperienced bookkeeper, he may justly question whether the figures have any real significance.

The A.H.A. committee on accounting might well take up with the American Institute of Accountants the idea of spreading more widely the knowledge of hospital accounting so that every certified public accountant called in to audit a hospital's books could compare the recommended system with the system he finds. Such a move might well expedite the adoption of sensible accounting practices in all hospitals—large and small.

HEADLINE NEWS

Hospitals Get AA-1 for Maintenance, Repair and Operating Supplies, Equipment

WASHINGTON, D. C.—Hospitals, schools, government agencies and welfare establishments were granted special privileges in obtaining maintenance, repair and operating supplies by the issuance on March 19 of Controlled Materials Plan Regulation 5A, which grants a priority of AA-1 to hospitals when it is absolutely needed.

No capital improvement of hospitals can be undertaken under the new order except that "minor items of productive capital equipment and minor capital additions or replacements not exceeding $100 (exclusive of cost of labor)" may be included. But materials for construction are still subject to the construction limitation order, L-41.

Certain items are also specifically excluded from the operation of the new plan, including printed matter and stationery, paper products, fuel or electric power, office machinery and equipment, fire hose and fire extinguishers.

No hospital can use the plan to increase its inventory above a "practicable working minimum" which will ordinarily be construed to mean a sixty days' supply and never more than a ninety days' supply.

Except for seasonal activities, a hospital cannot buy in any one quarter more than 30 per cent of the amount of maintenance, repair or operating supplies used during the previous calendar or fiscal year. For seasonal activities, the amount purchased in one quarter cannot exceed the amount of the same materials purchased in the corresponding quarter of 1942. But the amount purchased in a year must not exceed the amount purchased in the previous year.

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"Prevailing Level of Compensation" Defined in General Order 26

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—The term "prevailing level of compensation" used by the War Labor Board in General Order No. 26 exempting certain hospital employes from the wage and hour freeze was defined in March by W.L.B. through the insertion of the following additional statement in General Order No. 26:

"General Order No. 26 refers to prevailing level of compensation for similar services in the community. The prevailing rate for a given occupation is the modal or most common rate paid in the community. It is not the highest rate found in the community.

"For certain hospital occupations, such as, for example, stenography, the prevailing rate of pay need not be restricted to similar services in hospitals in the community. For other occupations, such as nursing, the prevailing rate would probably be found in hospitals."

In collaboration with the A.H.A. Wartime Service Bureau, the W.L.B. has worked out a form for hospitals to use in reporting wage or salary changes made under General Order No. 26. It bears the Budget Bureau number 07-R003. The form is simple and brief.

Congressional Investigation of Hospital Facilities Urged

WASHINGTON, D. C.—On March 3 a resolution was submitted to the House of Representatives which proposes an immediate investigation of the hospital problem throughout the United States, surveying all hospital beds available for members of the armed forces and of the merchant marine and any and all persons engaged in warfare.

In addition, existing civilian hospital facilities and the hospital problem in the United States as a whole as affecting not only war industries but industry in general would be studied. Finally, recommendations as a result of this exhaustive investigation would be submitted to Congress along with a report.

Such a study is somewhat similar to the one recommended to the A.H.A. by Maury Maverick at the midwinter meetings.

In addition, numerous bills regarding medical and hospital care of veterans have been introduced. These will be found on the next page.

N.R.P.B. and Social Security Board Plans Vague Regarding Health Aspects

WASHINGTON, D. C.—On March 10, President Roosevelt submitted to Congress a social insurance plan covering freedom from want from the "cradle to the grave" prepared by the National Resources Planning Board. A week later the Social Security Board made public its annual report for 1942 with its own recommendations for extending the social security program.

Both reports were cautious and vague regarding medical and hospital aspects of the social security program.

The National Resources Planning Board stated as a basic theory that "the health of the individual is the concern not only of the individual himself but of society as a whole." As a result there should be, in the postwar world, governmental assurance of "adequate medical and health care for all, regardless of place of residence or income status, and on a basis that is consistent with self-respect."

This was followed by an additional recommendation for "immediate action by the government, in cooperation with the medical profession, to formulate plans which enable the patient to budget expenses over a reasonable period and to contribute toward the costs of care according to his ability, and which at the same time assure to medical personnel a decent livelihood commensurate with the high costs of their professional training."

According to a United Press report, a nation-wide system of new public hospitals and health centers, regional and local, to be financed by the federal government through appropriations to states and localities, was advocated as one of the foremost methods of assuring adequate medical care for all.

The board also suggested steps for geographical redistribution of doctors, dentists, nurses and other medical personnel more nearly in proportion to need. Adequate nutrition was stressed.

The fact that the health aspects of the National Resources Planning Board's

(*Continued on page* 116)

Volunteer Nurses' Aides Get New Duties

WASHINGTON, D. C.—The cleansing enema, perineal care or the external douche as a part of the bath routine, the filling and application of hot water bottles, the preparation and application of hot and cold compresses over areas of unbroken skin and the observation of patients who are receiving intravenous fluid or recovering from anesthesia are new duties of volunteer nurses' aides that have recently been approved by the American Red Cross, according to an announcement received during March.

These are to be added to the list of procedures previously authorized although their actual performance is subject to the approval of the individual hospital.

The application of hot and cold compresses can include application of Kenny packs if the patient is past the communicable stage of the disease and if the hospital nursing staff assumes responsibility for teaching and supervising this treatment.

While a nurse aide may observe a patient receiving intravenous fluid or recovering from anesthesia, the responsibility for interpreting the significance of these observations must be carried by the nurse.

When hospitals request nurse aides to perform duties that have not been authorized by the Red Cross, they should ask for specific duties and be willing to give necessary additional teaching and to assume responsibility for the work of the aide.

The request should be approved by the professional subcommittee and the area office nursing service. Aides who are to be given advanced training should be chosen carefully from the group that has completed 150 hours of service.

Production of Limited Number of Dishwashers to Be Allowed

WASHINGTON, D. C.—Hospitals will have first call on the limited number of commercial diswashing machines permitted under Limitation Order L-248 issued March 5, according to Everett W. Jones.

PD-638A applications from these institutions will be handled by the hospital branch of the Governmental Division.

Because of the small amount of material available for this production (25 per cent as much as was used in 1941), dishwashers will go only to the most essential uses.

These machines are being made from the least critical materials possible and are designed to stand up for the duration. Hospitals, Mr. Jones points out, should make every effort to repair their existing equipment since it is obviously superior to that which will be manufactured under present limitations.

New Form for Heat Exchangers

WASHINGTON, D. C.—Prospective buyers of heat exchangers must now apply for "authorization to purchase" on the revised form PD-615. The new form requires complete information regarding the delivery promises made by manufacturers in order to determine delivery dates. It thus combines the functions of two previous forms, PD-615 and PD-615A, and simplifies the filling out of the information required in the application, as well as serving as an authorization form.

BILLS AFFECTING HOSPITALS

Congress has passed a bill, H. R. 1749, to provide medical treatment and hospitalization, domiciliary care and burial benefits, now available to veterans of World War I, for officers and enlisted men and women (Army and Navy Nurse Corps and Waacs) employed in the active military or naval service of the United States on or after Dec. 7, 1941, and before the termination of World War II. Thus veterans of the present war will receive all available benefits.

H. R. 1879, introduced by Representative Bennett of Michigan, asks a federal appropriation of $700,000 to construct in the Upper Peninsula of Michigan a 150 bed veterans' hospital.

H. R. 1936, introduced by Representative Maas of Minnesota, proposes an appropriation of $2,000,000 for the expansion of hospitalization facilities for the dependents of the personnel of the Navy and Marine Corps. It passed the House on March 15.

H. R. 1673, introduced by Representative Walter of Pennsylvania, proposes an appropriation of $1,500,000 federal funds for a 400 bed veterans' hospital. The hospital is to be located in the eastern part of Pennsylvania.

H. R. 1754, introduced by Representative Miller of Connecticut, asks an appropriation of $350,000 to increase the bed capacity of the veterans' hospital at Newington, Conn., to some 500 beds.

H. R. 1764, introduced by Representative Green of Florida, proposes an appropriation of $10,000,000 for acquiring a site and constructing a 1000 bed naval hospital in Florida.

Hospital Bureau Urges President to Appoint Hospital Commission

President Roosevelt was requested to appoint a commission to study "the problem of the most efficient use of the country's hospitals in connection with the war, the commission to consist of representatives active in the management of voluntary, public and governmental hospitals and national health agencies" in a resolution adopted February 25 by the annual meeting of the Hospital Bureau of Standards and Supplies of New York.

The adoption of the resolution came after an address by Maury Maverick, director of the Governmental Division of W.P.B. This address was similar to the one which he gave earlier in February to the mid-winter hospital conference in Chicago.

The resolution points out particularly the need to provide full hospital care and rehabilitation of both wounded soldiers and the civilian population. It was also recommended that the commission investigate other problems affecting hospitals in war time, such as construction, personnel shortages, food rationing and the shortage of materials and equipment.

Another resolution by the same body urged standardization of sizes, styles and qualities of hospital equipment.

Revised PD-1A Form Available; Supplemental Forms Eliminated

WASHINGTON, D. C.—Form PD-1A has been revised. Copies of the revised form are now available in W.P.B. field offices. After April 15 only the new forms will be accepted for processing. Major changes in the form are: (1) change from a column type of form, with accompanying instruction sheet, to a block type of question and answer form; (2) incorporation of the clearance form used in processing the application to speed handling, and (3) addition of some questions not previously asked to eliminate the need for supplemental forms.

Hospital administrators are urged by Everett W. Jones to read and follow the instructions carefully and to give a complete story.

Hospitals Still to Get Beds

WASHINGTON, D. C.—Order L-49 on beds, springs and mattresses was amended February 23. Of immediate interest to hospital officials is the paragraph titled "special exemptions," which states: "The restrictions in this order shall not apply to the production of bedding products for the following purposes: . . . (2) in fulfillment of a specific order of, or contract with, a hospital or sanitarium."

W.P.B. Answers Queries on Photographic Film and Paper

WASHINGTON, D. C.—An amendment to L-233, the photographic film and film base order, is intended to clarify the order without effecting any change in the substance.

Questions raised concerning priority assistance in order to obtain these items and some misunderstanding in the application of ratings brought an appeal from Everett W. Jones to the Consumers' Durable Goods Division, W.P.B. This division in March gave the following summing up of the subject as it stands at present:

"Photographic paper in general can be purchased without a rating. If one supplier cannot ship immediately, there are others that can unless the item required is of a special size or is not ordinarily carried in stock. Special types of papers, such as Direct Positive, require an A-1-j rating for immediate shipment. How long this condition will obtain is open to question.

"Photographic film is being rationed by manufacturers on a percentage basis of a customer's purchases in 1942. If someone who made no purchases in the past wants film, a rating would be necessary and could be granted only if the film was to be used for essential work. Moreover, if for any reason more film is required than a person is entitled to on the rationing basis, a rating would be necessary.

"However, it is rare that a rating higher than A-5 is required to obtain usual types of cut film. In most instances, A-8 or A-9 is sufficient. In the case of films of the reproduction type A-3 is generally required.

"For 16mm. Kodachrome film, the required rating varies from A-1-j to A-1-a, according to prevailing military demands. For 16mm. Kodachrome duplicating film, ratings from A-1-j to AA-5 are necessary.

"It is believed that the extension of AA-2X ratings under Order P-43 is definitely a misusage."

Civil Air Patrol to Fly Plasma

WASHINGTON, D. C.—Arrangements have been made with the Civil Air Patrol to fly blood plasma supplies into stricken areas in the event of emergencies, it has been announced by the Office of Civilian Defense. When it becomes necessary to supplement local stocks of plasma for the treatment of casualties and other methods of transportation are inadequate, the regional medical officer of the O.C.D. will ask the aid of the appropriate wing commander of the C.A.P. These arrangements apply for all states except those located within the jurisdiction of the Western Defense Command.

National Hospital Day Observance Will Stress Recruitment of Nurses

Owing to the war, the yearly observance of the birthday of Florence Nightingale, which in the past has featured events designed to get people inside hospitals, has given way to a functional program.

R. F. Cahalane, chairman of the A.H.A. Council on Public Education, stated recently that "hospitals haven't the personnel or time to devote to the usual observance of the day. But if we can't get the people to the hospitals, we can take the hospitals to the people through radio and newspapers. May 12 can also serve as a peg on which to hang student nurse and nurse aides recruitment programs. Accordingly, the council has made contact with the O.W.I., the National Nursing Council for War Service and other groups, and the plans as developed emphasize hospital personnel shortages."

The American Hospital Association upon request will provide a package of posters, folders and press releases for the publicizing of the day.

Some hospitals plan to develop elaborate programs. Donald Rosenberger, chairman of the National Hospital Day Committee for Pennsylvania, has arranged a comprehensive program for the hospitals of Erie, Pa. Every hospital will be visited by groups of high

school pupils, each of whom will write a report of her visit and the best reports will be printed in the newspapers and broadcast over local stations. Window displays have been arranged through the cooperation of the local stores, hospital supply houses and the hospitals.

C. Rufus Rorem, American Hospital Association, will speak over an Erie radio station into every schoolroom in Erie. His subject will be nurse recruitment. He will also address the joint women's auxiliaries at a tea. Later in the day he will speak over WERC on an Eastern states hookup and is scheduled to lead a forum discussion over WLEU in the evening.

Physical Therapy Supplies Adequate

WASHINGTON, D. C.—An investigation of the physical therapy situation by the hospital branch of the Governmental Division reveals that in spite of the limitation order announced in the March MODERN HOSPITAL, large stocks of this equipment exist in manufacturers' and distributors' hands; that the number of the allowable types to be manufactured is large, and that there is no immediate prospect of a shortage so far as hospitals are concerned.

TO PURCHASE NURSES' SHOES

Washington, D. C.—A nurse may purchase with ration coupon No. 17 either work or street shoes as she requires. If she needs another pair, she may obtain a special purchase certificate from the local ration board. Her request to the board must be supported by a statement from her superior, *e.g.* superintendent of nurses, that the extra pair is actually needed. The same regulations apply to other members of the hospital staff.

Supply of Surgical Sutures Increased by New W.P.B. Order

WASHINGTON, D. C.—The supply of surgical sutures will be considerably increased following the passage of an amendment to Conservation Order M-220 on February 24. Packers who slaughtered more than 1000 sheep last year must fill purchase orders for sheep intestines that are to be used as sutures before they can make deliveries of those intended for other purposes. Buyers of intestines to be used as surgical sutures must certify their intended use to the packers.

The removal of the geographical limitation and the inclusion of small packers (effected by redefining the term "slaughterer") will serve to increase the supply. The original order issued last September applied only to meat packers east of the Continental Divide who had slaughtered more than 100,000 sheep during the previous year. However, processing plants have begun to operate on the West Coast (formerly plants for manufacturing surgical sutures were all located in the Middle West) and other plants will probably be established west of the Rocky Mountains.

War, Navy Departments Announce New Hospital Expansion Projects

WASHINGTON, D. C.—In the last month the War Department has announced the following hospital construction projects and acquisition by lease of hotels to be converted into Army hospitals:

Award of a lump contract to R. P. Farnsworth and Company, Inc., New Orleans, for construction of facilities for an Army General Hospital in Tuscaloosa County, Alabama, in excess of $2,000,000. Work will be supervised by the Mobile district office of the Corps of Engineers.

Authorization for construction of a station hospital in connection with an Army installation in Smith County, Texas, to cost approximately $1,000,000. Construction is being supervised by the Denison District Office of the Corps of Engineers.

Acquisition by lease of the Dante Hospital and the Polk-Pacific Garage property in San Francisco for conversion into an Army station hospital. Work is under the jurisdiction of the San Francisco District Office of the Corps of Engineers.

Acquisition of a leasehold interest in the Oakland Hotel, Oakland, Calif., for conversion into an Army station hospital. It, also, is under the jurisdiction of the San Francisco District Office of the Corps of Engineers.

Additional construction for a medical section to cost between $50,000 and $100,000 in Hamilton County, Ohio. The Meyer-Hecht Company, Cincinnati, was awarded the contract.

Federal Works Administration recently announced the fact that a new suburban hospital is to be built in Bethesda, Md., by the federal government with Lanham Act funds. J. Dewey Lutes, former administrator of Presbyterian Hospital, Chicago, has been appointed head of the new hospital. Its estimated cost is $665,000. Bids were called for March 25.

Public Buildings Administration will supervise the construction. An allotment for maintenance and operation of $68,850 has been made by the Federal Works Agency to the Suburban Hospital Association at Bethesda.

By June 30 approximately 40,000 hospital beds will be provided by existing naval hospitals and the current construction program. The expansion that is planned for 1944 is 20,000 additional beds in hospitals by acquisition of existing structures, such as hotels, by expansion of present hospital facilities and, possibly, by the construction of new naval hospitals.

Bill to Commission Women Physicians in Army, Navy Considered

WASHINGTON, D. C.—The House Military Affairs subcommittee has under consideration a bill to permit commissioning of women doctors in the Army and Navy.

Introduced by Representative Sparkman of Alabama, H.R. 1857 proposes that during the present war and for six months thereafter such licensed women physicians and surgeons as the Secretaries of War and Navy may consider necessary shall be included in the medical departments of the Army and Navy.

Secretary Stimson, in a letter read to the committee on March 12, said that he had no objection to the measure. Mr. Stimson pointed out that the War Manpower Commission has limited to approximately 10,000 the number of doctors the Army can take during 1943. Dr. Frank Lahey, head of War Manpower Procurement and Assignment Board, endorsed the commissioning of women doctors in his testimony before the subcommittee on the measure.

Doctor Lahey asked that there be sufficient flexibility in the bill so that women could be used where they are most needed.

New Ruling Places Sterilizer Equipment Under Strict Control

WASHINGTON, D. C.—Sterilizer equipment has been placed under strict control through General Limitation Order L-266, issued February 24. In addition, simplification and conservation measures were imposed. The order covers sterilizer equipment of various types used primarily in hospitals and in the offices of doctors and dentists. Used or rebuilt equipment and parts or materials for the repair or maintenance of existing equipment are exempted from the provisions of the order. Small nonpressure and certain laboratory sterilizers (covered by Limitation Order L-144) are likewise exempted. Pressure cookers are not affected.

Deliveries are restricted to the armed forces, Lend-Lease, Board of Economic Warfare, distributors and persons having specific authorization from W.P.B. Application should be made on Form PD-556 and the need for the equipment and the use to which it will be put should be shown in detail.

Simplification and conservation measures restrict the manufacture of sterilizer equipment to the following types and sizes: (1) pressure sterilizer (cylindrical); (2) pressure water sterilizer (one tank only); (3) nonpressure instrument sterilizer; (4) nonpressure utensil sterilizer; (5) vertical laboratory pressure sterilizer (cylindrical); (6) bulk pressure sterilizer; (7) field sterilizer, and (8) bedpan washers. The first five types may be manufactured in specified sizes only.

The use of critical materials, including monel metal, stainless steel, copper and nickel, is prohibited in the manufacture of nonpressure types of sterilizers except when they are necessary in electrical circuits, control and safety valves and gauges. Hot-dipped galvanized sheet steel will be used instead of the prohibited materials. It is believed that the simplification measures will increase production by approximately 25 per cent.

HELP IN FUEL SHORTAGE

WASHINGTON, D. C.—Hospitals in areas seriously affected by the fuel oil shortage can receive financial aid under the Lanham Act to permit them to convert heating facilities from fuel oil to coal, according to a special interpretation obtained in March from the Federal Works Agency.

Red Cross Brings Latest Films to Army Hospital Patients

Patients in U. S. Army hospitals are being shown first-run Hollywood films as part of the hospital motion picture service of the American Red Cross. This project brings for the first time 16 mm. movies to bed patients in Army hospitals on a nation-wide scale.

Motion picture producers are cooperating with the Red Cross in making these films available in 16 mm. sizes within thirty to sixty days after the national release date. It is estimated that before the end of this year the hospital ward circuits will cover more than 350 hospitals.

Bookings will be handled at Red Cross national headquarters and films will be distributed to approximately 150 circuits.

Control of Rubber Goods Transferred

WASHINGTON, D. C.—Various baby and hospital articles were transferred by O.P.A. on March 1 from price control under regulations for rubber drug sundries to control under Maximum Price Regulation No. 220 for certain rubber commodities. The articles included are: hospital sheeting and blankets; pillow cases; baby bibs; baby pants; crib sheets; diaper and utility bags; diaper covers; mattress covers and coveralls; nursery hospital sheeting, and nursery seat rings.

Your Hospital Will PROFIT *by* SHARING

A. A. KARAN, M.D.
DIRECTOR, BETH MOSES HOSPITAL
BROOKLYN, N. Y.

Nine ways in which hospitals can pool their resources are outlined here and readers can doubtless think of many more

POSITIVE action by hospital groups to establish formulas for sharing hospital facilities has been disappointingly limited. One probable explanation for this lies in the organization of our hospital associations and another lies in the administrative pattern of voluntary hospitals.

Institutional rather than individual membership is now the rule in most hospital associations. This plan of organization recognizes that boards of trustees are the governing bodies of hospitals and that the administrators are their executive officers. Unfortunately, institutional trustees do not usually have the time to attend meetings of hospital associations. Positive action of hospital groups is thus limited because the administrator cannot make decisions in hospital policy prior to consultation with, and sanction of, his board of trustees. This restrains the promulgation of new ideas to meet new and urgent situations.

There is no denying the critical situation in which hospitals now find themselves. The war with its attendant difficulties in the purchase of supplies and equipment, the shortage of nonprofessional employes and the insufficiency of medical staffs and technical personnel makes it obligatory for hospitals to share their facilities and, to some degree, their personnel. Hospitals must help one another both to support the war effort and to render adequate service to the sick.

Hospitals now must join in a reciprocal sharing program. The first step in instituting such a program is a survey of hospital facilities in a given community to determine the needs of each institution and the things that one may possess in sufficient amount to be of help to other institutions. It is reasonable to expect that the pooling of facilities will enhance the service rendered to the patients in all the hospitals comprising the group.

The extent to which this can be done can be determined by a careful study on a group basis. Hospitals need not be asked to donate services to one another without equitable compensation. A unit cost schedule, therefore, could be established and each institution could be credited with services rendered or charged with services received; accounts could be settled periodically.

The extent of facilities that may thus be shared on a reciprocal basis will vary with the hospitals, their neighbors and their localities. A number of suggestions are herewith noted for special consideration in such a study.

The Specialties

As a rule, departments of pathology, chemistry, anesthesiology, roentgenology and physical therapy are directed by specialists who devote their entire time or, at least, considerable time to these departments. Since the outbreak of the war many hospitals have lost the services of such department heads to the armed forces.

Under the reciprocal sharing program a group of hospitals would find it more desirable and practicable to maintain proper standards in these departments by sharing personnel and equipment than to remain in isolation with a department of poor quality or with no department at all. The pathologist or other specialist could divide his time between two or more institutions. It should be practicable to arrange for one hospital in a group, for example, to perform the more complicated and highly technical laboratory examinations for the other hospitals of the group in its own laboratory.

The same general routine could be followed in the utilization of x-ray and physical therapy facilities. The sharing of costly radio therapy and physical therapy facilities should prove of particular mutual benefit to the hospitals concerned.

The division of the time of a physician-anesthetist between two or more institutions for the actual administration of anesthetics may be difficult because of concurrent operating room schedules. However, several institutions could make excellent use of his services for the purpose of supervising the department and training interns and nurses in the administration of anesthetics.

The Pharmacy

If one hospital in a group entering into a reciprocal sharing program has a well-equipped pharmacy with a well-trained and competent pharmacist he could be assigned to supervise the preparation of the more complex pharmaceuticals for the other institutions. The simpler tasks of drug dispensing may be left to less

trained individuals since the acquisition of qualified pharmacists is becoming ever more difficult.

The Blood Bank

In most hospitals space is at a premium. Many an administrator has been hard put to it to find room for "that blood bank" and finally has arrived at a makeshift arrangement, not because he lacked ingenuity but because he could not stretch floor space. It is obvious that a blood bank can operate more efficiently and satisfactorily in institutions with 1000 transfusions during the year than in one that has a third that number. In order to avoid clinical complications it is also wise to assign a full-time technician instead of interns, who are constantly changing services, to do the serologic examinations, keep accurate records and supervise the cleaning and sterilization of glassware, needles and tubing.

The operation of a blood bank by several institutions on a cooperative basis is more economical and efficacious than it can possibly be in a small institution working alone. Recently, in New York City, seven large hospitals have joined a blood and plasma exchange bank. These hospitals have undertaken to process and make available blood and plasma to other hospitals without blood banks under a blood donor or blood donor plus cash exchange arrangement.

In-Patients

In the past year many a voluntary hospital's bed capacity has been taxed to the limit on one service or another, both ward and private. However, the same types of private accommodations or ward services in each of several hospitals may not be filled to capacity at the same time. If a group of hospitals could arrange to extend reciprocal courtesy privileges to selected staff physicians for the purpose of admitting at least their private patients to all the hospitals in the group it would prove to be helpful to the patient, the physician and the hospital personnel.

The courtesy privileges might be limited to those instances in which the staff physician's parent institution has no accommodations for his patient at the time and suggests that the patient be admitted to another hospital with which reciprocal relations exist. Similar arrangements could be made for service patients. For example, if one hospital has no vacant beds on its medical service the patient may be advised by prearrangement to enter another voluntary hospital within the reciprocity group that is fortunate enough to have an available bed.

Out-Patients

Hospitals that have heretofore been rendering excellent out-patient service to the medically indigent in their communities are unable to extend the same quality of service now in some of their clinics because of the depletion of their medical staffs. It is not likely that the same clinics of the out-patient departments of every hospital in a locality have been depleted to the same extent. Reciprocity arrangements should, therefore, be established among hospital out-patient departments for the referral of patients to clinics that can render adequate service.

Laundry for Spray Painting

The following is another illustration. Hospital A has an efficient laundry that is not utilized to capacity. However, it has no adequate equipment for re-enameling its metal furniture. Hospital B has an inefficient laundry because of obsolete equipment that cannot now be replaced, but it does have a well-equipped spray shop and a competent sprayer. Reciprocal sharing of these facilities would obviously be helpful to both institutions.

Butcher and Baker

Small institutions probably have no need for full-time butchers or full-time pastry cooks in their dietary departments. The time of such employes can be shared by two or more institutions. The boning of meat and the baking can be done in one institution and the finished products can then be delivered to other hospitals in the group.

Chief Engineer

At this time when highly skilled maintenance engineers are scarce, the hospital that is fortunate enough to possess one cannot part with his services for any considerable part of his working day.

However, it is probable that he could be spared for the time required to act in a consulting capacity to one or more less fortunate hospitals. In this way critical materials so necessary for the war effort can be conserved by hospitals and their plants can be maintained with greater efficiency.

Centralized Schools

The feasibility of establishing central or cooperative schools of nursing and of dietetics and departments of medical social service certainly merits consideration. These programs may be, and in some instances have been, undertaken in collaboration with various colleges and universities.

Participation on the part of hospitals in a reciprocal sharing plan necessarily imposes a certain degree of dependency of one hospital upon others. Theoretically, this implies a loss of complete autonomy. However, if absolute autonomy results in deficiencies of services rendered to the individual patient and the community, then the voluntary hospital does not fulfill its obligations to the community that supports it.

For such a program to function satisfactorily a spirit of mutual confidence and trust must exist among the governing bodies of the hospitals concerned. Each hospital should be willing to give as well as take. It is also of the utmost importance that the hospital administrators who are charged with the actual administration of the program be willing to work with each other cordially and harmoniously.

Such cooperative ventures will, in a measure, result in a departure from the competitive spirit hitherto existing among voluntary hospitals, but this should work out for the common good. A group of federated hospitals that receive substantial financal support from one source or a group of church hospitals should find such a joint effort highly profitable.

The present war emergency warrants a trial of such a reciprocal sharing program. If it proves of value during the emergency, it may form a basis for greater coordination of our hospital system after the war.

Physical Therapy in a Background of Beauty

GERTRUDE R. FOLENDORF

SUPERINTENDENT, SHRINERS' HOSPITAL FOR CRIPPLED CHILDREN, SAN FRANCISCO

AT THE Shriners' Hospital in San Francisco, we had a physical therapy department which, when the hospital was built in 1923, seemed entirely adequate and served our purposes for many years. We did not have a pool, however, and since pool treatment has been found useful for many types of orthopedic cases we began to give some study to the idea of either renovating the old department or erecting a new wing.

We considered first our actual present needs and then anticipated any expansion that might be needed in the coming years. After thoughtful study we decided that not only would a new wing meet our requirements better but that the cost would be approximately the same.

One whole year was spent in studying plans and materials. We wanted a unit that would serve both out-patients and in-patients, a unit that would be flexible and that could accommodate two or four physical therapists and an occupational therapist, if necessary.

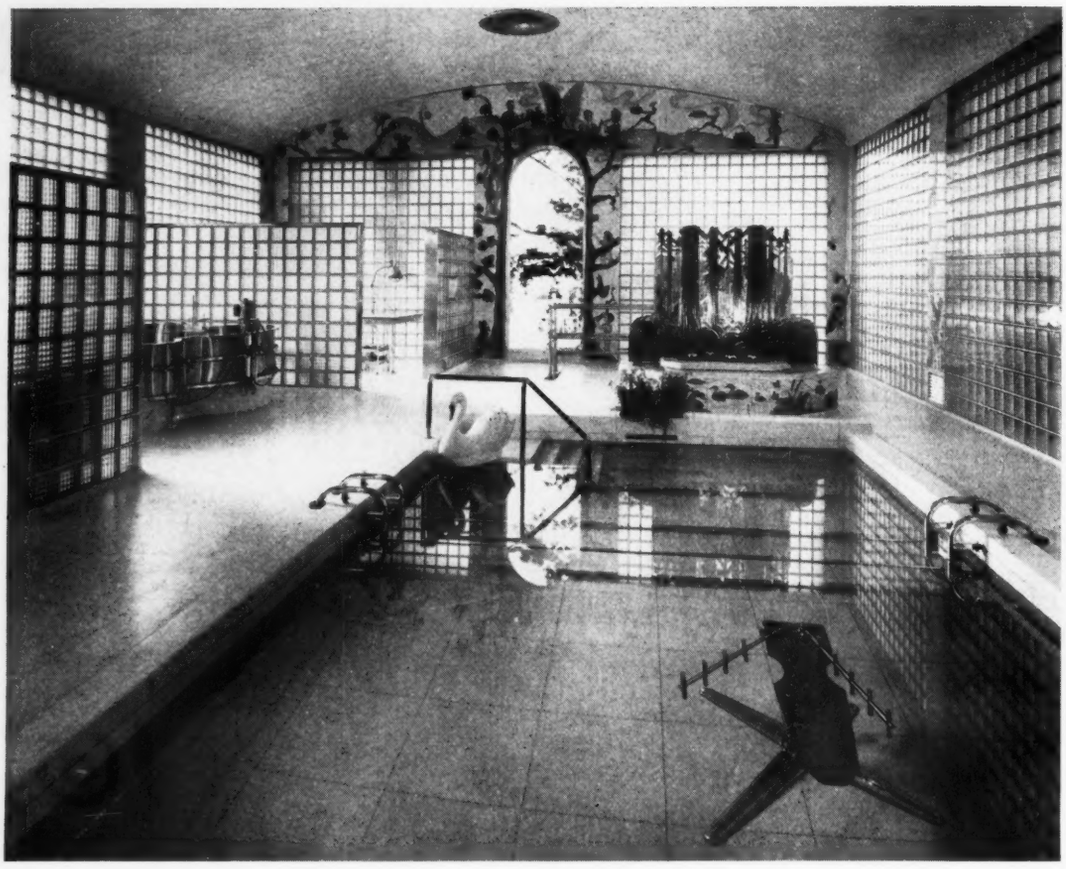
The final decision was that the new wing should be attached to the old building so that all house patients could be taken for treatment from the wards to the new department without elevator service. Our building is of a low, rambling type, spread over much of a 3½ acre plot of land and lends itself to growth nicely.

The new unit is two stories high, the first floor is easily accessible from street car and bus lines, which stop directly in front of the hospital, and it is on this floor that out-patients receive their treatments. They can enter and leave the building without going through the hospital proper.

An interesting feature in the main treatment room is the ceiling. It is a colored map of North and South America made in linoleum. The rounds of the climbing bars are painted in various colors to intrigue the children.

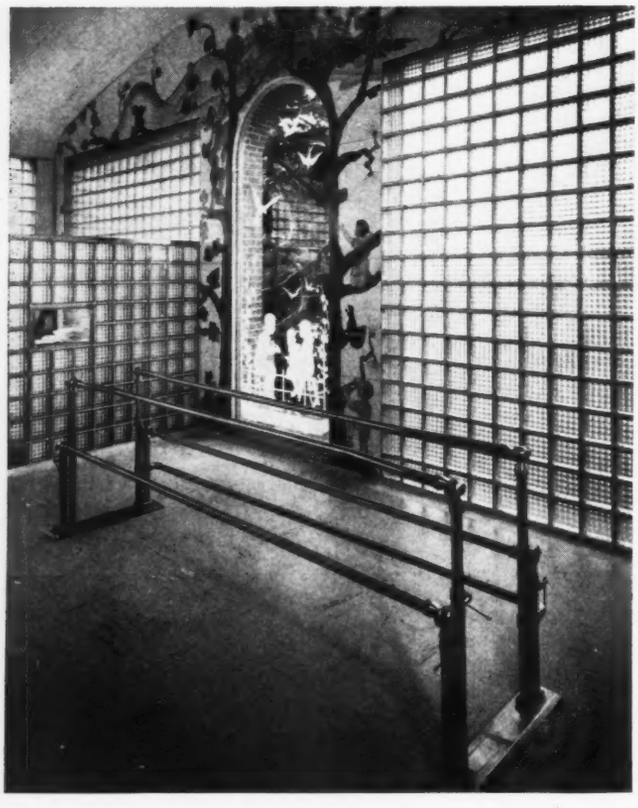
The lower part of the plate glass windows has been sandblasted in 1 inch strips to resemble venetian blinds. It has the advantage of obstructing the vision from the outside without curtains, at the same time enabling those within to look out upon the gardens surrounding the building.

The second floor is for in-patients. Two years previously we had experi-



The 22 foot pool is fed from an artistically constructed fountain that has giant redwood trees as its motif. The pool room also contains an underwater therapy tank equipped with electric turbine ejector and aerator. Entrance to the department is controlled by electrically operated glass doors.

Below, left: Close-up of the mural decorations depicting scenes from "A Child's Garden of Verses." The murals are painted on Princess blue vitrolite. Below, right: In case of an air raid, the hospital is ready with its own fire truck equipped with sand buckets, shovels and other fire-fighting equipment.



mented with glass block in renovating our out-patient department. We found it satisfactory and appealing and surprisingly inexpensive. It has an added advantage over other building materials in that the maintenance costs are practically nil.

Recent experiments prove that this block glass withstands concussion from bombs much better than does plate or sheet glass. It cracks but does not splinter or shower the fragments. This is gratifying to us since San Francisco is in the combat area. Except for supporting piers, all outside walls are of glass brick. The entire wing is air conditioned. The fresh air is heated before entering and there is a continuous circulation with regulation of humidity. All partitions are of block glass, giving abundance of light with the added advantage of privacy.

Floors throughout, including the floor and walls of the pool, are of terrazzo with the exception of those in the massage and spastic rooms, which are of rubber tile because the physical therapist has to stand a great deal in giving treatments.

Terrazzo, which is usually made up of sand and cement with an aggregate of marble chips, is susceptible to disintegration when exposed to chlorine; therefore, we selected an aggregate of crushed vitrolite, the culls that are left over in the making of vitrolite sheets.

Aluminum was used instead of brass for expansion joints, which as a connecting link with the blue and white terrazzo laid out in 24 inch squares makes a most attractive floor.

Our pool is 22 feet long and has a depth of 4 feet at the deep end, with steps ranging up to 2 feet 6 inches, thus providing various depths of water for walking and other pool treatments. The rails for support are readily movable so that children of all ages can be quickly accommodated.

An innovation is the construction of the hydraulic lift for lowering and elevating patients. It was placed outside the pool rather than in it as many patients had found considerable difficulty in operating the lift from inside a pool.

Water for the pool is filtered and chlorinated and runs from an artistically constructed fountain. The back splash of this fountain is made of synthetic material through which the light filters to form a picturesque setting. A model depicting giant redwoods was made first and then the synthetic material was poured and polished.

An unusual feature is the linoleum map on the treatment room ceiling.

The arched ceiling is of painted acoustical material which was chosen not only for its sound absorption qualities but because it was sanitary and easy to keep clean. In painting this ceiling, care was taken not to seal it but to cover it. The paint was carefully mixed and sparingly used.

We had determined a long time ago that whenever we made any changes or built new additions we would endeavor to keep the child's point of view, *i.e.* we wanted to hold the child's interest and, in addition, to instill in him a desire for and a love of beauty and harmony. Consequently, in planning the interior, we gave much thought to selecting a material that would be permanent and sanitary and would also lend itself to decoration. Princess blue vitrolite was chosen and murals were painted on the vitrolite. Suggestions for designs were obtained from illustrations by Ruth Mary Hallock in "A Child's Garden of Verses," by Robert Louis Stevenson. The vitrolite slabs were installed with a jointing arrangement similar to that used in stone work to give it a massive appearance.

Entrance to the department is controlled by heavy electrically operated glass doors.

A series of steam pipes installed in open cabinets serves both for drying wet garments and for heating blankets and towels.

An underwater therapy tank with electric turbine ejector and aerator was installed. The impact of this aerated thermal stream upon the tissues acts as a unique massage.

The building was the gift of a San Francisco gentleman whose love for children and all things in nature is well known to this community. It was because of this that the redwood trees were made a motif of the fountain.

Adequate Convalescent Care

is the shortest road to health

CLAUDE W. MUNGER, M.D.

DIRECTOR, ST. LUKE'S HOSPITAL, NEW YORK CITY, AND
ST. LUKE'S CONVALESCENT HOSPITAL, GREENWICH, CONN.

ALTHOUGH institutions for the care of convalescents are not evenly distributed over the United States, we have not neglected this phase of the treatment of the sick. For the many fine facilities we do have, we should be doubly thankful in this time of national trial.

The dislocation of members of the armed forces from their families, the migrations of workers to obtain defense jobs in distant localities and the general disruption of the even tenor of peace-time life all add, unfortunately, to the problems of the sick patient who has left the acute disease hospital but who is not yet well enough to fend for himself.

The doctor and the social worker, in effecting a prompt cure of physical ailments and a ready adjustment of the personal and social problems that are so frequently the companions of illness, will find convalescent care needed by more patients.

Institutional Care Needed

Convalescent care in institutions is needed especially by the person who has no family or whose home, family or finances are inadequate to the extent that he cannot obtain adequate care outside of an institution.

The well-to-do patient seldom wants or needs institutional convalescence because he can provide for himself an environment suitable to prompt recovery after acute illness. That is why one seldom finds a convalescent institution that is self-supporting. With few exceptions, convalescent homes must have large sources of supplementary income if they are to give good care to those who need it most. The student of convalescence needs to appreciate this fact from the start if he is to understand the subject and be able to plan or administer institutions for meeting this definite community need.

Presented at the 1942 annual meeting, section on convalescent care, Welfare Council of New York City.

Every patient who enters a convalescent home has already been ill and, in most instances, if he had any money at the onset of illness he has already depleted his finances in attempting to pay hospital and doctors' bills. It follows quite naturally that many patients can pay nothing for convalescent care, no matter how much they need it.

The number of communities in which the welfare authorities are willing to pay something for convalescent care for public charges is still far too small but is believed to be on the increase. There is need for education of these officials and of the appropriating bodies as to how often convalescent care "clinches the cure" and prevents relapses that are likely to result in expensive readmissions to acute disease hospitals. With the latter institutions as overcrowded as they have to be in many areas, the need for convalescent facilities becomes all the more urgent and could be provided at less financial outlay than new acute disease hospitals could be built. One may venture to hope that some communities will recognize this fact and start, in war time, a useful service that could remain a valuable post-war community asset.

By its very nature, the convalescent institution cannot stand alone. It must be closely tied in with the work of the acute disease hospital or hospitals whose patients it receives. It reaches its maximum usefulness when it is in active team-play with other organizations.

Convalescent institutions may be branches of individual hospitals or they may serve more than one hospital or related activity. In the New York area, examples of the first type are the Harkness Home of the Presbyterian Hospital and St. Luke's Convalescent Hospital, each of which functions as an integral part of a general hospital for acute diseases. The Burke Foundation and the Loeb Memorial Home are examples of convalescent institutions that accept patients from various sources.

Better to Keep Beds Filled

While connection with but one referring hospital doubtless simplifies the problems of management for the convalescent home, the procedure is not without its disadvantages and is less conducive to efficiency in the use of beds. If there are several sources of patients, it is easier to keep the beds filled.

The convalescent institution's facilities should be so geared that it can accept patients as soon as they are able to leave the acute disease hospital. In certain homes, a patient is not eligible for admission if he still requires simple surgical dressings or if he needs to lie down for more hours a day than the home's regimen prescribes. This is regrettable and I make a plea that the convalescent home so arrange its service that it can pick up the convalescent patient when he is ready to leave the acute disease ward.

Care must be exercised not to go too far in this adaptation to the general hospital's problem of clearing its wards to make room for new admissions, lest the convalescent home become a different type of institution, one in which people are sick rather than convalescent. However, lack of flexibility of admission criteria is reducing the usefulness of some otherwise excellent convalescent homes. In the stress of war, this should not be allowed to happen.

It is the general and proper custom that patients who relapse in the convalescent home and again need general hospital service are promptly readmitted by the referring hospital.

Prompt restoration of the sick to health is imperative today, and proper convalescent care is needed to "clinch the cure"

Convalescence presents a number of problems that are not regularly encountered with acutely sick patients in the parent hospital. In the first place, the patients are ambulatory, thus they have more contact with fellow-patients and with other people than is the case during their stay in the general hospital. The convalescent patient finds that he has a great many more personalities to which he must adjust his own personality and activities. He is no longer in the comparative cloister of a hospital ward but he must "get along" with others in the recreation room, the dining room and the occupational therapy shop.

Ambulant Patients More Disturbing

A patient may complain and, indeed, be uncooperative while in bed but in that horizontal state he is much less effective in disturbing others than, potentially, he can become when he is up and about. This explains why the convalescent home must exercise reasonable precautions against the admission of persons who might disturb other patients. Frank psychopaths cannot be retained, of course, but in milder situations a psychiatrist can often help the patient and the staff of the home so that the patient can adjust himself and receive the care he needs for his somatic disease.

Family interferences tend to be less in the convalescent institution, especially if it is in the country and not too accessible and if extensive visiting is discouraged.

Institutional spread of infection is another problem. It is easier to keep infection out of the convalescent home than out of the acute disease hospital, but once it gets started it is more likely to spread owing to the more frequent patient-to-patient contacts. In the convalescent hospital with which I am associated, an entire pavilion for children is being equipped with ultraviolet lights for air sterilization as a means of studying the efficacy of that fairly new plan for reducing air-borne spread of upper respiratory maladies. Some excellent results have been obtained in schools by this method and it seems reasonable to anticipate similar, if less extensive, benefits with ambulatory convalescents.

Many institutions, being specialized, do not accept both children and adults. If they accept both, there should be well-segregated facilities for each.

The problems of race, nationality and religion are likely to be accentuated in the convalescent institution. Most of these situations can be handled by intelligent management, however, and the need for convalescent care has no racial or sectarian barriers.

One Class of Care Preferable

Except in a large institution, I would favor the maintenance of only one class of care. There would not be enough private and semiprivate patients to justify special facilities for them. A good grade of ward service will suffice for those who need convalescent care and will be accepted by the occasional person from the "private side" who wants institutional convalescence.

Location of convalescent facilities is a question for local determination. Certainly, the country is to be preferred, but there are successful homes located in crowded cities, too. The relative inaccessibility of a country location has been mentioned as an advantage. On the other hand, the transportation of patients by bus or car, over long distances, is not a factor if the home is situated on some desirable site near the referring institution.

Adjunct activities are important in convalescence, such as schools for children, occupational and recreational therapy, outdoor walks and the milder outdoor games, and well-stocked libraries to meet varying reader tastes.

A good dietitian and dietary service are prime necessities. Special diets, scientifically prepared, should be readily available. The patient's special diet prescription, if he needs one, should accompany him to the convalescent home. The diabetic must suffer no relapse as a result of improper dieting during his convalescence. Gain of weight is often an important part of a successful recovery from illness. Food for the patients should be plentiful, the menus well-balanced and the cooking good.

Must Continue Medical Care

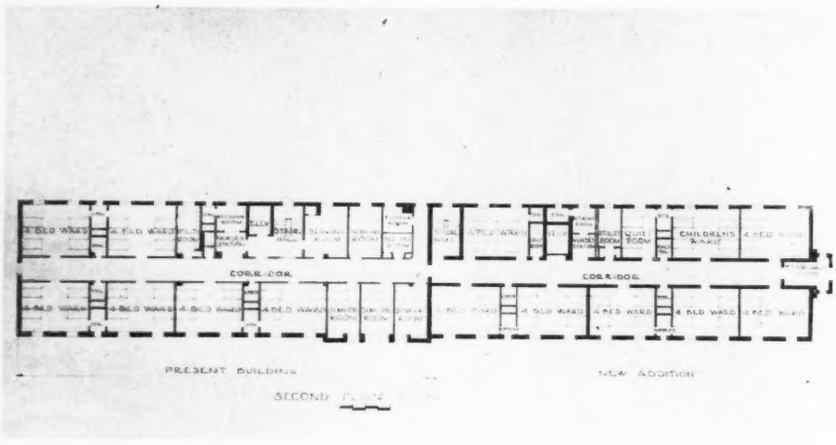
Medical care, of course, should be a continuation of that given in the parent institution. It is necessary that there be regular visits by physicians of sufficient frequency to give good medical supervision. Facilities for performing simple laboratory tests and even equipment for simple radiography are desirable. It is also desirable that the patient's medical record, or at least a full summary of it, accompany him to the convalescent institution, where progress notes are entered and the record is finally filed in the parent institution. This is easier to do when the home serves one hospital of which it is, in effect, one of the integral departments.

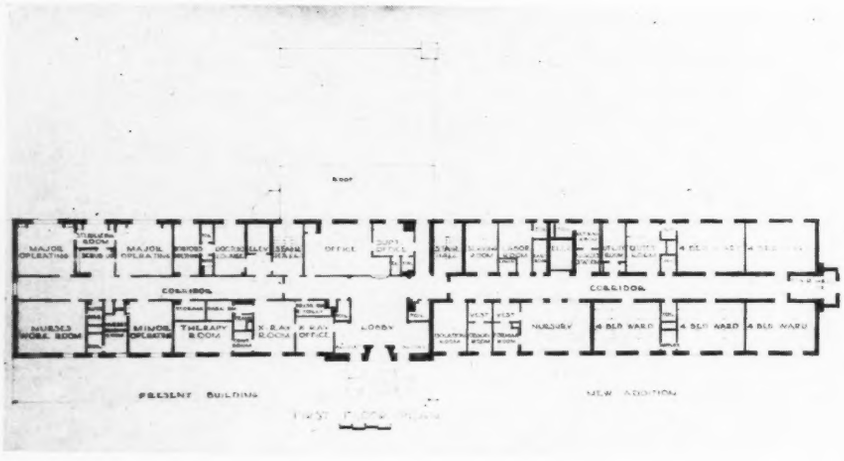
Both the professional and the lay staffs of the parent hospital should be constantly reminded of the work of the convalescent institution that serves it. Likewise, the staff of the home must familiarize itself with the peculiar needs and procedures of the referring institution. Without this, the proper team-play is less likely to be realized.

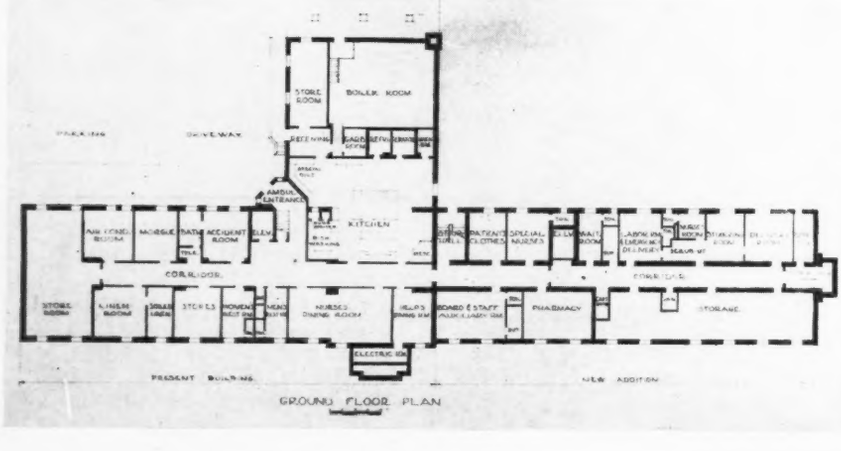
Convalescent care can be, and in fact is considered, one of the refinements of hospitalization. However, it is a necessary service if we are to perform our full duty to the sick, especially the sick who are underprivileged.

In this time of supreme national effort it is not merely important, it is imperative, that the sick be restored effectually and promptly to a state of productive efficiency. Proper convalescence from illness should be accessible to all who need it. In this period there should be no retrogression in the number and quality of our convalescent facilities.

WAR-TIME Construction Calls for INGENUITY





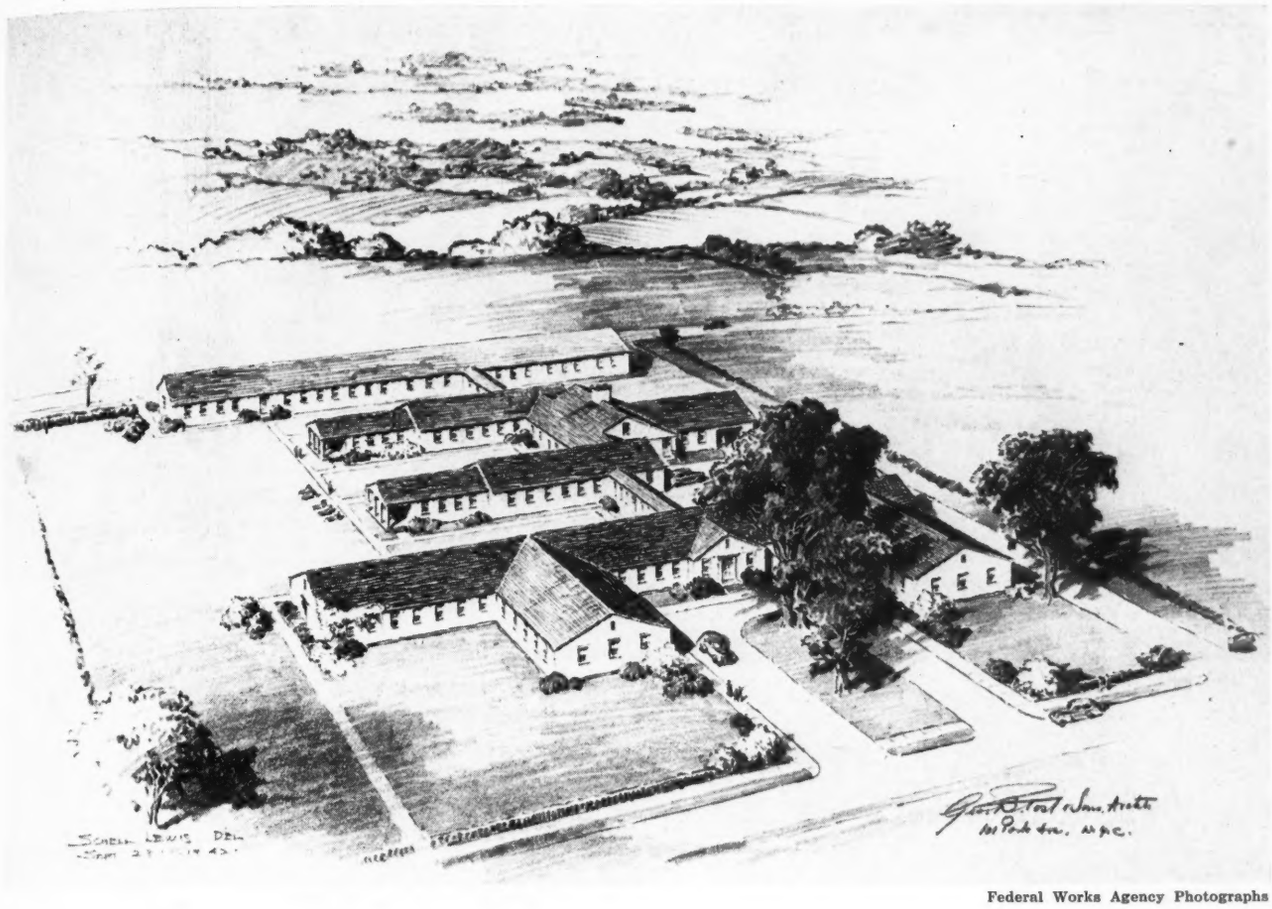


CONSTRUCTION of medical facilities, including hospitals, in those communities in which sudden population bulges attributable to the war impact overtaxed and dislocated existing services is an integral part of the war public works program of the Federal Works Agency.

Of the $300,000,000 appropriated by Congress under the Lanham Act to provide war public works, allotments in grants and loans approximating $37,000,000 had been approved by the President for construction of 284 hospital, health and clinical center projects to cost about $50,000,000. Applicants were to put up about $13,000,000. In each instance the U. S. Public Health Service had certified the war-connected need of the project. This was the F.W.A. hospital program as it stood in May 1942.

At about this time the mounting needs for critical building materials began to be reflected seriously in the war effort; new priority rulings were clamped down on materials essential for implementing the fighting forces overseas—for ships and planes, tanks and munitions. Structural steel and reenforcing concrete, scores of ferrous metal products, literally hun-

In spite of restrictions imposed by priorities, hospitals are being built in some heavily populated defense areas. One of these is the addition to the Brooks Memorial Hospital, Dunkirk, N. Y., the drawing and plans of which are shown here. The addition will expand the hospital's facilities by 58 beds and 20 bassinets. Will Alban Cannon, Niagara Falls, is the architect.



Federal Works Agency Photographs

Another war project made necessary by increased population is the 100 bed hospital at Massena, N. Y., for which a federal allotment of $150,000 in Lanham Act funds was approved. Work on the first section, which will provide 50 beds, was started January 4. Architects are George B. Post and Sons, New York.

dreds of items required in the construction of hospitals, went on the priority lists.

Of necessity, the war public works construction program was subjected to the most stringent reviews and resurveys by F.W.A. engineers, the federal and other health authorities and by the military. The need for patients' beds was undiminished but the matter of providing these in the light of the new criteria became extremely difficult and in some instances impossible.

Architects were instructed to redraw their plans and to reduce specifications to the absolute minimum use of critical materials. The federal works administrator, Maj. Gen. Philip B. Fleming, declared that hospital "construction as usual" was out for the duration. Shortage of critical materials had made it impossible, he said, to approve any plans for "monumental" hospital structures, and wherever possible only temporary construction could be approved.

"I hope to see the time," General Fleming said, "when every man, woman and child in this country, regardless of means, will have easier access to the kind of medical treatment they need. Government must continue to play an important part in the realization of that program. Adequate medical service for the people presents a problem that all the people together must solve.

"The tremendous difficulty in the way of expanding hospital facilities at this time constitutes one more of the many sacrifices all of us must make to the winning of the war. And yet the picture is not without its brighter side. For the building we postpone now can go on that reserved shelf of future projects that will help to tide us over in the period of postwar adjustment that is coming."

On this shelf many architects have placed the plans that were approved when essential materials seemed to be available. Generally, the applicants understood the more vital need and willingly and patriotically relinquished the plans in favor of structures for temporary use.

Back to the drawing boards went the architects with the long list of critical materials to be eliminated from the new plans before them. Their ingenuity was taxed and many of them recognized a challenge in War Production Board's priorities. No hospital or hospital addition was to exceed two stories, except where needs were vitally urgent, and construction was to be of frame or masonry wall bearing with wood floor joists for temporary use.

Today, some of these new hospital projects are completed, others are under construction. In instances in which the government meets the full cost of construction the projects are leased to the hospitals for the duration and for one or two years thereafter.

The new war-time buildings promise to serve the emergency need and many of them are very handsome.

St. Mary's New Staff Room

MODERNIZED for the Medical Staff

SISTER M. PATRICIA, O.S.B.

ADMINISTRATOR, ST. MARY'S HOSPITAL, DULUTH, MINN.

AMONG the functions of a hospital is the education of the staff and hospital personnel. Since most hospitals are not connected with a medical school, the educational program for the medical staff centers around the weekly pathological conference, the monthly meeting of specialty groups and last, but not least, the monthly staff meetings.

In the older hospitals, the staff room has shared with the record room the dubious honor of being consigned to just any place at all that could be released from bed space. Yet our doctors are obliged to attend these meetings. It would seem fitting then that more thought be given to the appointments of the staff room.

The medical staff conference room at St. Mary's Hospital, Duluth, Minn., was of adequate size and to all appearances was a desirable place in which to hold meetings. It had blackboards, projectors of various types, x-ray view boxes and indirect lighting. From time to time, however, such remarks reached the administrator's ears as, "Oh those seats!" There were also complaints about the interruption whenever a doctor was paged and of the difficulty of having to climb over others' legs in order to procure a seat. (The entrance was in the front and seats near the door filled quickly.) There was the ever-present smoke problem, too, and something in the way of improvement seemed to be in order.

Inasmuch as the seats seemed to be the chief item of complaint, samples of modern auditorium seats were procured and the doctors were invited to try them out. Their choice fell upon the latest styles, widths and cushioned seats. Because of lack of funds, however, purchase was impossible and the idea was dropped.

Quite a while later one of the medical staff members came to the office and asked, "What about those seats?" Much to our surprise, he wished to pay for them. Thus, began the renovation of our medical staff hall, since beautiful new chairs could not go into the present setting.

Floor plans were studied with a view to better seating arrangements and a more efficient call system. The room was right-about-faced by moving the officers' desk from a large raised platform across the front to a small one set across a rear corner diagonally opposite from the entrance. A four view x-ray box was fitted into the wallboard partition that cut off the corner, replacing a three view box on portable uprights. Small blackboards were placed in the side walls to the right and left of this corner and an additional board, equipped with a shaded light, was provided for doctors' calls. The speaker's stand is at the left.

The study of seat plans resulted in a staggered arrangement to right and left of one main aisle, which provides unobstructed view of the platform, blackboards and view boxes. The aisle plus generous passing space along the walls makes access to the seats easy.

Centrally placed in the aisle is a wooden cabinet of a height suitable for moving picture machines and projectors of various types. The inside of the cabinet provides a safe storage place for these visual aids. An electric outlet in the cabinet eliminates the necessity for long extension cords, and there is also a switch controlling the ceiling lights.

New millwork in all the windows, which were equipped with venetian blinds over black-out curtains, and an acoustically treated ceiling gave the appearance of a new room. Walls are painted orchid and the woodwork is a light cream, while the seats chosen have covers of turquoise blue plush and tan leather. A ventilating system controls the smoke problem and four large fluorescent lights give adequate illumination.

The large, framed and glass-enclosed changeable sign board for the monthly analysis of hospital service is given a prominent place on the wall to the left of the officers' platform.

This hall is available to many groups besides the medical staff of the hospital. But it was designed primarily for our own staff men, and if no one else ever used it we would feel amply repaid by the looks of relaxation on the faces of tired practitioners when they settle down to attendance at a staff conference.

CLINIC VISITS

Reflect the Trend of the Times

EMIL FRANKEL

DIRECTOR, DIVISION OF STATISTICS AND RESEARCH
NEW JERSEY DEPARTMENT OF INSTITUTIONS AND AGENCIES

"WHAT should we do about clinic services in war time? Should they be curtailed or dropped altogether? Should we, instead, adopt a program of early medical care and how?"

These are the queries of an experienced administrator of a flourishing out-patient department in a large metropolitan hospital. The comment is added that "some of the physicians advise closing down clinics and at the same time refuse to see any clinic patients in their private offices."

The query regarding the out-patient department's place in medical care in war time by this administrator and many others is prompted, no doubt, by the falling off in the attendance at clinics, simultaneously with the growing shortage of available clinic physicians.

The trend in the volume of out-patient services in general hospitals noted in recent months is quite contrary to observations made not so long ago by a joint committee of the American Hospital Association and the American Public Welfare Association, namely, that "the number of out-patient departments and the service provided by them have increased by leaps and bounds.

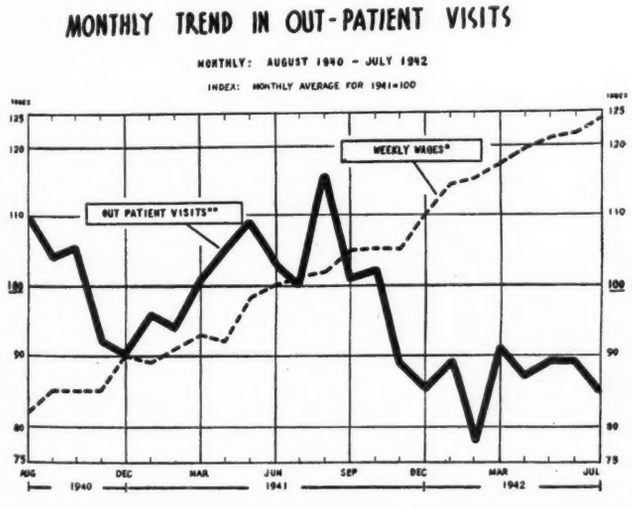
"This increase has been due to several factors, including the change of clinic clientele from the destitute to persons who are ordinarily self-supporting but who cannot meet the costs of private medical care (this change of clientele was accentuated during the depression), and recognition of the advantages, both economic and scientific, of providing ambulatory service for the sick poor in out-patient departments where consultant and diagnostic services are available."

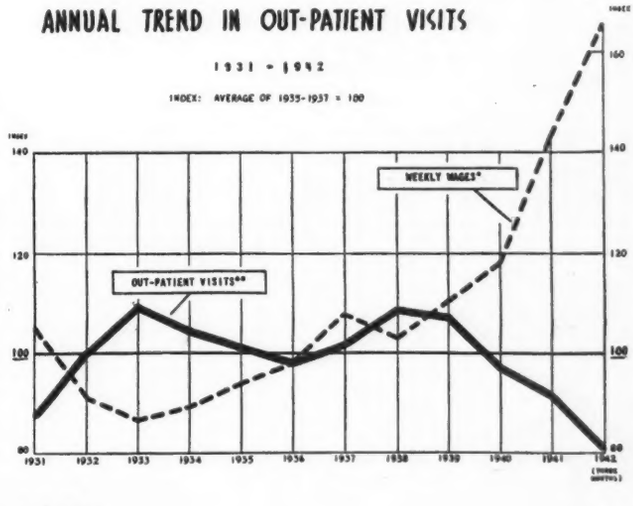
On the basis of figures currently gathered by the New Jersey Department of Institutions and Agencies in cooperation with the New Jersey Hospital Association, it is possible to follow accurately the trend in the out-patient department services in representative New Jersey general hospitals over a period of years. The following figures covering the period 1931 through 1941 are especially significant since they include years of great economic change, the outbreak of the second World War and America's actual participation!

Year	*Number of Out-Patient Department Visits**	*Per Cent Change Over Preceding Year*
1931	652,153	.....
1932	749,792	+15.0
1933	811,540	+ 8.2
1934	775,033	− 4.5
1935	751,806	− 3.0
1936	733,236	− 2.5
1937	759,267	+ 3.6
1938	805,558	+ 6.1
1939	799,350	− 0.8
1940	726,830	− 9.1
1941	685,010	− 5.8

*To 30 representative voluntary general hospitals.

The years 1931 to 1933 mark the depth of the economic depression and in that period out-patient department visits increased 24.4 per cent. With the gradual improvement in the economic situation between 1933 and 1936 out-patient department visits declined 9.7 per cent. A sec-





*Average weekly wage of wage earners in New Jersey manufacturing industries.
**Total monthly out-patient visits to 30 voluntary general hospitals in New Jersey.

ondary depression occurring in 1937 was reflected in a larger number of clinic visits that year and the year following. Beginning with 1939 a perceptible decrease in out-patient visits is to be noted.

America's entrance into the war, accompanied by an unprecedented expansion of industrial activities, has sharply influenced our entire social and economic outlook. A deep imprint is being left upon all institutions dealing with human beings and the out-patient department of the general hospital is no exception.

The accompanying monthly figures on out-patient services clearly reflect the constantly changing situation and the impact of the war industrial program upon clinic attendance.

	*Number of Out-Patient Department Visits**		
Month	*1940*	*1941*	*1942*
January		54,785	50,649
February		53,603	44,463
March		57,988	52,169
April		59,753	49,815
May		62,131	51,075
June		58,691	51,102
July		57,323	48,604
August	62,817	66,462	.....
September	59,490	57,579	.....
October	60,257	58,078	.....
November	52,611	50,754	.....
December	51,535	48,769	.....

*To 30 representative voluntary general hospitals.

In an editorial appearing in a recent issue of the *Journal* of the Medical Society of New Jersey it is stated that "owing to the large increase in employment and the higher wages now being paid, especially in war industries, there are a reported decline in free clinic visits and an increased demand upon the time of the private physician remaining in practice to look after the civilian population."

The graphic charts accompanying this article illustrate with nice precision the opposite direction the movements of out-patient visits and wages take in times of an economic upswing. They bear out the general observation that as people are earning wages that allow them a margin to pay for medical services, they are less likely to go to hospital clinics and more likely to seek out the services of a private physician.

A somewhat novel view of this phase is expressed by a hospital administrator who is also a physician. He writes: "I believe one of the most interesting things in hospital statistics today is the apparent universal falling off in visits to the out-patient department. This, I believe, is explained by the fact that most everybody is too busy to think of minor ailments and lets them get well without interference from the doctor. Also, the class of people who go to the out-patient department earns a great deal more money than it ever has before and, consequently, is able to go to the doctor's office."

In the present situation the organized medical profession of New Jersey sees an unusual opportunity for the private practitioner of medicine to demonstrate to those who voluntarily seek his services three claims that are consistently made by the medical profession. As stated in the editorial referred to, these are:

"First, that the quality of service given to private patients is vastly superior to that furnished in any other way.

"Second, that the personal interest manifested by the physician in the diseases and defects of his own patients provides not only the necessary medical services but also a sense of personal security which is readily recognized and appreciated by the patient.

"Third, that the personal relationship existing between the private patient and his doctor is of prime importance in the recovery of the patient, and that this service not only is appreciated by the patient but is a part of his demand for medical service."

Doctor—Hospital—Patient *benefit by* INCLUSIVE RATES

WILLIS J. GRAY

SUPERINTENDENT, CHARLES GODWIN JENNINGS HOSPITAL, DETROIT

THE common day rate, *i.e.* adding to the patient day rate extra charges for the various kinds of special service given, is by far the oldest method of charging for hospital care. This method, now growing antiquated, is discouragingly expensive to the patient, annoying to the physician and unwieldy and confusing to the hospital.

The term "flat rate" is often confused with "inclusive rate." Actually, a flat rate is a stipulated sum of money charged by a hospital for a limited and particular amount of hospital service. If a hospital makes a charge of $75 for a maternity case of ten days' stay in a semiprivate room, then that charge usually includes room and board, regular nursing service, delivery room service, including anesthesia, care of the baby, routine laboratory tests, ordinary drugs, medicines and dressings —and that is all.

The hospital that operates on an all-inclusive rate system places at the patient's disposal all of the regular special services of the institution; only exceptional services are precluded. Every patient that enters under this plan, therefore, is entitled to any type or amount of available regular services prescribed by his attending physician; the use of such services is practically unlimited. The hospital usually publishes a predetermined schedule of charges, depending upon the number of days of hospitalization, which shows the complete cost of the patient's entire stay in the hospital.

Inclusive rates may embrace the following types of medical and allied services: room and board, regular nursing service, ordinary drugs and medicines, dressings, operating room service, including anesthesia, laboratory service, diagnostic x-ray service, electrocardiography, basal metabolism and physical therapy.

Exhibit A—Comparative Analysis

Day Rate	*Total*	*Per Patient Average*
Room	$ 69,399.60	$ 84.22
X-ray	7,720.88	9.37
Laboratory	13,917.36	16.89
Operating room	9,401.84	11.41
Drugs and medicines	7,391.28	8.97
Oxygen therapy		
Dressings		
Telephone	444.96	0.54
Restaurant	403.76	0.49
Nurses' board	3,716.24	4.51
Miscellaneous	428.48	0.52
Physical therapy	799.28	0.97
Total service—Day Rate	113,623.68	137.89
Inclusive Rate		
Room, X-ray, Laboratory, Operating room	97,166.08	117.92
Drugs and medicines	7,399.52	8.98
Oxygen therapy		
Dressings		
Telephone	444.96	0.54
Restaurant	403.76	0.49
Nurses' board	3,716.24	4.51
Miscellaneous	428.48	0.52
Total service—Inclusive Rate	109,559.04	132.96
Total extra service given	4,064.64	4.93
Total amount charged to patients	109,559.04	132.96
Total inclusive rate admissions	824	

Exhibit "A" sets forth a comparative analysis of the cost of hospitalization under the common day rate system as compared to the cost of the same amount of hospital service on the inclusive rate system.

Exhibit B—Total Operating Costs

	Operating Cost for Special Services	*Patients Treated*	*Cost per Patient*
Operating room	$19,622.41	1015	$19.33
X-ray	24,729.68	2094	11.81
Laboratory	8,633.85	3985	2.17
Physical therapy	2,459.45	305	8.06
Total	55,445.39		

Exhibit "B" shows a classification of the total operating costs for all hospital services covering 1748 admissions during the year studied. Figures also indicate actual unit cost for each type of service rendered.

Exhibit C—Special Services

	Patients Treated	*Per-centage*	*Unit Cost*	*Cost of Service Given*
X-ray, laboratory	154	18.70	$ 13.98	$ 2,152.92
Laboratory	58	7.03	2.17	125.86
X-ray, operating room	1	.01	31.14	31.14
Laboratory, operating room	407	49.85	21.50	8,750.50
Laboratory, operating room, physical therapy	5	.60	29.56	147.80
Laboratory, physical therapy	4	.50	10.23	40.92
X-ray, laboratory, operating room, physical therapy	10	1.20	41.37	413.70
X-ray, laboratory, operating room	128	15.50	33.31	4,263.68
X-ray, laboratory, physical therapy	27	3.30	22.04	595.08
Operating room	3	.04	19.33	57.99
No special services	27	3.27		
Total	824	100		16,579.59
X-ray	320	39	11.81	3,779.20
Laboratory	793	96	2.17	1,720.81
Operating room	554	67	19.33	10,708.82
Physical therapy	46	1	8.06	370.76
Total				16,579.59

Exhibit "C" was prepared in order to find out the various combinations of special services received by most patients. It has often been said that many patients do not always receive all of the services they should for what they pay for under inclusive rates. Of the 824 cases studied, only one patient received only x-ray and operating room service; three patients received only operating room service, and 27 did not receive any special services at all.

Exhibit D—Income and Cost Comparison

Hospitalization	*Admissions*	*Inclusive Rate Factor*	*Income*	*Unit Cost*
4 Days	100	$25.00	$ 2500.00	
5 Days	82	30.00	2460.00	
6 Days	77	33.00	2541.00	
7 Days	99	36.00	3564.00	
8 Days	76	39.00	2964.00	
9 Days	39	39.00	1521.00	
10 Days	42	39.00	1638.00	
Over 10 days	309	39.00	12051.00	
Total	824		$ 29239.00	$ 35.48
Deduct:				
Total extra service given (Exhibit A)			4064.64	$ 4.93
			$ 25174.36	
Net cost of special services (Exhibit C)			16579.59	20.12
Income over expense				
Surplus earned on inclusive rate			8594.77	10.43
				$ 35.48

Exhibit "D" is a summary of income and cost comparison of special services, showing surplus earned.

Since a hospital must be ready, willing and able to deliver any and all types of special medical and allied services, Charles Godwin Jennings Hospital, Detroit, feels that it is reasonable, equitable and just that the unavoidable per diem cost of modern hospital preparedness be shared equally among all patients hospitalized.

At this hospital a year's study recently completed shows that the use of inclusive rates as a means of charging for hospital service to patients pays an operating surplus as large as $10.43 for each case admitted. In view of the surplus earned, the patient average for extra services given by the hospital amounted to $4.93 a case.

The accompanying exhibits have been prepared after a careful and detailed analysis of 824 cases admitted during the twelve months ended Dec. 31, 1940. Each account studied was recalculated in two ways: (1) according to the regular day rate method and (2) on the regular inclusive rate basis. The total sum of money paid by all 824 patients, according to the inclusive rate, amounted to $109,559.04, averaging $132.96 per patient stay for an average of eight days. After calculating the same amount of hospital service on the day rate method it was found that these patients would have paid $113,623.68; an average of $137.89 a case for a hospital stay of eight days. The difference between the inclusive rate and day rate calculations shows that these patients received an added amount of service totaling $4064.64, or $4.93 per case hospitalized.

Patients received an average of two x-ray examinations each. The number of laboratory examinations averaged 10 per patient. Before adopting the inclusive rate plan, however, x-ray examinations ran about one per patient and laboratory tests, four per patient. The increased use of operating room facilities has been negligible. We have, however, found that much more use is now being made of the physical therapy department facilities. About 5 per cent of our patients receive some form of physical therapy. Electrocardiography and basal metabolism are extremely popular services. On an average, one out of every four patients receives an electrocardiograph reading and one out of five patients has a basal metabolism examination.

Despite all of the increased amount of special services rendered, under the inclusive rate the hospital has enjoyed a fair amount of surplus earnings, as indicated in exhibit "D."

The Charles Godwin Jennings Hospital provides a reasonable day rate charge plan for the patient who only requires from one to three days of hospitalization. For this brief hospital stay, the patient is charged the regular day rate and should any special services be necessary, the cost is added to the regular day rate charge. In the event, however, that it becomes necessary for the patient to remain in the hospital beyond the third day, then after three days the regular inclusive rates apply and all hospital expenses incurred from the first day are included in the published table of rates.

The table of published inclusive rates for each accommodation is intended for the convenience of those interested in an accurate estimate of the expense of a patient's hospital stay. Special rates are provided for maternity and tonsillectomy cases.

We are all aware that it has been customary in certain hospitals to

give special consideration to tonsillectomy and maternity cases in the matter of rates; the justice of this arrangement has not been called into question. Yet, if we were to examine these rates, we would be compelled to admit that they have not been formulated on a systematic basis of hospital costs.

The greatest need in hospitals today is standardization of hospital charges and quality of service. A hospital rate plan that is commensurate with the progress of our economic system can be made to pay dividends in a great many ways if it is developed on a mathematically sound basis.

The introduction of an inclusive rate system is often met with a considerable degree of objection on the part of patients who remark, "Why should I pay for services I do not need?" Such an objection is not always justified, as we well know that a fairly large percentage of hospital admissions come into the hospital as medical cases and later develop into surgical cases. On the other hand, it must be remembered that the patient never knows just exactly how much service he is going to require.

The inclusive rate system is equally advantageous to the patient, the physician and the hospital, as the following summary indicates:

Advantages to the patient: 1. The hospital that operates on this plan never denies the patient any essential services, as frequently happens under the common day rate system.

2. The very fact that charges for hospitalization are predictable in advance invariably appeals to the patient and promotes friendlier relations between patient and physician.

3. Anxiety regarding the high cost of hospitalization, often associated with prolonged illness, is obviated because the inclusive rate structure by virtue of arithmetical processes equalizes special service charges.

4. Years of practical experience under the plan demonstrates that patients' diagnoses are arrived at earlier, which results in shortening the hospital stay.

5. The inclusive rate system contributes immeasurably toward promoting better health in the community.

Advantages to the doctor: 1. When the sick person first learns that hospitalization is imperative, the physician is immediately confronted with two direct questions: "Doctor, how long must I remain in the hospital and what will my hospital bill amount to?" and "How much are you going to charge me for your services?"

The first question can be answered emphatically and accurately. The second question must be left to the discretion of the physician, but since he knows the answer to the first question he is in a better position to answer the second question in a relatively shorter time than he ordinarily would.

2. Because of the unrestricted and unlimited use of special service the attending physician is able to rule out negative findings immediately until positive ones occur.

3. The physician, being unhampered, is encouraged to practice better medicine.

4. An early diagnosis enables the physician to begin curative treatment at once.

Advantages to the hospital: 1. Income is increased.

2. The volume of bookkeeping and general office routine are substantially reduced.

3. The hospital encourages its professional staff to practice better medicine.

4. The plan augments the general reputation of the hospital in the community by proving to the general public that its aim is to satisfy the patients' needs.

The high cost of hospitalization has always been of serious concern to patient, physician and hospital. One cannot safely dispute the fact that during war times the cost of hospital service naturally has a tendency to rise owing to conditions beyond our control. During this war period the cost of hospitalization is bound to increase, to what proportions no one knows. It would seem wise, at this time, for any hospital that is contemplating the inauguration of inclusive rates to start now because of changing trends. After it has once been established it is a simple matter to adjust rates up or down.

Pointers on Preserving

ADHESIVE PLASTER

1. Don't overstock. Adhesive plaster is made of precious rubber. A ninety day supply should suffice.

2. Play safe. Give departments enough for their immediate needs only. Sometimes, you may be able to supply individual cuts instead of a full roll.

3. Keep the supply as fresh as possible. Use up old before starting on new shipments.

4. Avoid storing in the rays of the sun or near steam pipes. Too hot temperatures will cause rapid deterioration. Keep in a cool, dry storeroom.

5. Be particularly careful not to drop, squeeze or otherwise mishandle rolls. When dented, they are difficult to unwind.

6. Before using, let the plaster warm up to room temperature (72° F.).

Follow these rules and you help your hospital and your country.

Guiding the Charitable Hand

MARY BOOTH

WISCONSIN ORTHOPEDIC HOSPITAL FOR CHILDREN
MADISON, WIS.

EVERYONE who has worked in a children's hospital is impressed by the generosity of the public but he is also impressed by its lack of imagination in choosing gifts for sick children.

It would be impractical to start a publicity campaign for the improvement of donations to hospitals, but the next time the president of the ladies' aid asks you whether you would like scrapbooks for the children, thank her profusely and admit you have a large supply at present. Tell her that the babies would love soft toys to play with and ask if the ladies would not prefer to make them instead.

You may get scrapbooks anyway, but don't be discouraged. You have planted an idea that will eventually bring in cuddly toys. It may be one superb elephant or a boxful of toys that have no resemblance to anything in the animal kingdom but the babies love them indiscriminately.

At Wisconsin Orthopedic Hospital for Children, Madison, we have found that a typed list of presents that are acceptable to a children's hospital is an effective reminder to us and to the inquiring public and has brought us a wider variety of donations. We also have patterns and samples of the type of toys that are useful. Children's Memorial Hospital in Chicago keeps a display of toys and games in the lobby as suggestions for friends and relatives of patients. The public has responded eagerly to these ideas.

The following is an explanatory list of inexpensive gifts that we have found effective.

1. *Scrapbooks.* These should be small and light, approximately 9 by 12 inches. The pictures must be securely pasted. The books can be made of either cambric for small children or paper for older ones. We use these for sick children who can have little activity and whose interest span is short.

Special scrapbooks, filled with a series of funnies cut from the papers daily, are enjoyed tremendously by the children. Daily crossword puzzles with the answers keep older children busy. The convalescent child needs more activity to keep him contented; therefore, new scrapbooks with pictures, paste and scissors are gratefully received.

2. *Sewing Cards.* We like them made of cardboard (suit boxes and the shirt boards, which are plain on both sides). Six by 12 inches is a good size. Draw outline figures of animals and flowers and then punch holes at least 1 inch apart with a large darning needle. For thread, use colored string with a shoestring-end so that no one has to worry about lost needles.

3. *Tray Cards and Favors.* The Girl Scouts in Madison have been cooperative in supplying place cards and favors for the trays. The children adore the novelties and save them as mementoes from the hospital. These projects are particularly good because they are inexpensive and can be designed for the abilities of the donors and are always received with delight by the invalids. Candy or nut favors should not be included. Children in a hospital are often on special diets.

4. *Stuffed Toys.* A nice soft animal or doll makes a fine bed companion for our sick babies. However, it should be firmly sewed and the features should be embroidered. Little fingers can find holes where none existed and pull off buttons and beads.

5. *Magazines.* Clean, old magazines are an excellent source of pictures for scrapbooks. Recent magazines, from one to six months old, except for current event magazines which become dated after a month, are welcome for reading material. *Child Life, Children's Activities* and scout magazines seem to carry no dates and are never brought in in large enough quantities. *Reader's Digest* is also in great demand in our hospital, where the age limit is 21 years.

6. *Checkerboards, Peg Boards and Pull-Toys.* These toys and games can be made of scrap wood, painted. One group of school boys made checkerboards out of crate ends and sawed the men from broom handles. The patients appreciated them so much that they kept disappearing almost as soon as they were put on the wards.

7. *Spools.* We use empty spools of all descriptions for stringing beads, spool knitting and blowing bubbles.

8. *Scraps of Cloth for Doll Clothes, Yarn and Crepe Paper.*

9. *Toys and Games.* Most gifts for a hospital should be nonbreakable and inexpensive. It is practically impossible to keep articles from rolling off a bed and delicate toys are broken in the fall. For the same reason toys and games are easily lost. Spring toys are not good because they do not work on beds and do not hold a child's interest for long and are easily pulled apart. The ten cent stores are full of toys that make excellent gifts.

10. *Other Suggestions.* Unbreakable mirrors, bed lights, hair ribbons, fans, small plants, seed boxes or terrariums and books of all kinds are always welcome.

Don't expect miracles to occur in your campaign for improving the type and variety of donations. After five years of suggesting, we still count our scrapbooks by the hundreds. The oversized ones we find useful in the out-patient department where little patients must wait to see the doctors. They are also given to these patients to take home when they leave. It is a friendly gesture on the part of the hospital and provides amusement for the trip home. On the other hand, we are now receiving a larger variety of gifts and we believe that greater numbers of people are using thought and intelligence in selecting them.

There are ways of balancing obstetrical facilities with the

RISING BIRTH RATE

EDWARD KIRSCH, M.D.

ASSISTANT DIRECTOR, THE JEWISH HOSPITAL, BROOKLYN, N. Y.

- MORE BEDS
- USE OF LUXURY SPACE
- SHORTER STAY
- HOME DELIVERIES
- NURSES' AIDES
- LOCAL ANESTHESIA

WITH the passage of the Selective Service Act in 1940 an increase in the birth rate was soon in evidence and this rise has been reflected in the steadily mounting demands for accommodations in the obstetrical divisions of our hospitals. The causative factors of this climbing birth rate are still in effect and there are no existing indications that can be interpreted as a trend toward an early decline in the birth rate.

During recent decades, hospitals have developed as the centers of medical activities for their communities. This development, traced both to the need for well-organized workshops for doctors and to the confidence placed by the public in our institutions, has been in great measure responsible for the growth of maternity services in many hospitals. The accommodations for obstetrical patients, generally adequate during peace time, are now inadequate to meet the great demands made upon them.

Demands Must Be Met

The general increase in employment and in the average family incomes and the desire of physicians to centralize and concentrate their work in one or a few hospitals to conserve time and energy tend to support the flow of the rising demands for more space for obstetrical cases. The hospitals cannot turn a deaf ear to these demands and must take steps to fulfill their obligations to the community at all times, especially during these periods of stress.

Every effort must be made to assist those physicians who remain in civilian practice and to aid the expectant mothers, many of whom are the wives of men in the armed forces who will be unable to be present or to assume the financial or other obligations related to "blessed events."

What can be done to improve existing maternity services and to bring about an expansion of hospital facilities to cope with the problems posed by a rising birth rate?

Expansion of the physical plant, always a possibility in prewar times, is almost an impossibility under existing conditions, and such a plan cannot be contemplated by all institutions with any assurance that such projects can be initiated or, once started, can be completed. Assuming that an additional building or floor could be constructed, the difficulties in obtaining new equipment and in acquiring added personnel are well known and present a serious problem for which there appears to be no immediate satisfactory solution. Or if we acknowledge the fact that additional space cannot be provided for by new construction (and if it were possible, would capital expenditure required for this purpose be justified on a long-term basis?), what can be done to increase the number of beds and to utilize available beds for a larger number of patients?

A careful survey of the physical plant can be conducted for the purpose of ascertaining whether more space can be set apart for maternity beds. Recent trends indicate a diminishing demand for some clinical services, such as pediatrics and certain of the surgical specialties. It might be possible, with minor physical changes, to utilize beds previously allocated to these services. Wards or rooms in close proximity to the delivery rooms and the nurseries are preferable but they are not absolutely necessary.

"Luxury" Space Can Be Used

A study of all available nonmaternity beds may well lead to a reallocation of beds in a way that is satisfactory to all services concerned. New space may be acquired by encroaching upon what may now be considered as "luxury space," *i.e.* large waiting rooms, nurses' restrooms, offices and solariums. Wards used for specific clinical research purposes may be converted into maternity wards, and the cases dispossessed in this manner can be absorbed by the general surgical and medical divisions.

Whatever changes are made should be considered temporary and the planning should be governed accordingly. The space obtained may not be ideal but rooms that are clean and in good repair and that possess necessary facilities may be adequate for temporary or emergency use.

If no additional space can be ob-

tained by utilizing rooms previously used for other purposes, extra beds can be placed in existing maternity rooms or wards. A room may be large enough to permit another bed to be placed in it. Often one or two additional beds can be placed in a ward by rearranging the furniture to suit the new plan.

Overcrowding, of course, is undesirable and must be avoided so that the health and safety of the patient will not be jeopardized, but "crowding" and "overcrowding" are relative terms. That which might appear to be overcrowding in the light of former standards may be consistent with the possibility of adequate, safe accommodations and good service. There has been a tendency to provide more than adequate space for certain types of accommodations. In the present emergency we must be content with less—especially if we have no choice of an alternative arrangement.

Stay Is Shortened

In certain communities the situation is so acute that plans have been put into effect whereby the patient is admitted to the hospital for the delivery and a period of from one to three days postpartum, after which, if everything is normal, she is transferred to her home by ambulance. This is far from the ideal to which many of us still hold but there can be no valid objections to this procedure under present conditions. The postpartum patient is rarely ill and the care of such a patient is not difficult. She can rest at home almost as well as in the hospital.

Such arrangements are not the most satisfactory but are safe and will allow a bed to be occupied by three patients instead of one during a two week period. The great advantage of this method is that it obviates the necessity for home deliveries.

The time may be near when some hospitals will be forced to adopt plans for home service if as many patients as possible are to receive the care to which they are entitled and which the community has been taught to expect.

Home obstetrics, although not the most desirable, can be practiced effectively. Cases for home delivery must be carefully selected. Preferably, they should be restricted to multiparous patients and, of clinical necessity, to those without complications. Such home deliveries may be a hardship to the doctor and the family, but we cannot afford to overlook the fact that they may become necessary in increasing numbers. Doctors should provide themselves with obstetrical kits for home use. The hospital, whenever possible, should make provision for emergency ambulance service for maternity patients following the onset of postpartum complications after deliveries in the home.

Other efforts can be made to shorten the hospitalization period as much as possible. Patients should not be admitted until labor has begun or until the appearance of complications that require hospital care. Not infrequently patients have been admitted to allay their own apprehension or to suit the convenience of the attending obstetrician.

The usual postpartum hospitalization period of from ten to fourteen days can be reduced to nine or even eight days. Most competent obstetricians agree that this length of time is sufficient, provided the patient is permitted to be out of bed two days before discharge. Multiparous patients who have had normal deliveries and uneventful postpartum courses can readily be discharged on the eighth day to rest at home. Again I wish to emphasize that such a course of action is not ideal but is dictated by the shortage of available beds.

Transfer to Nonmaternity Bed

When the infant is stillborn or premature or when it must be transferred to the pediatric ward for treatment, the mother can be transferred to a nonmaternity bed in another part of the hospital until she is ready for discharge, thus releasing a bed for another obstetrical patient.

Cesarean sections, uterine dilations and curettages and therapeutic abortions can be performed in a "clean" operating room in the general operating room suite or in a special room used for this purpose in the obstetrical unit rather than in the delivery rooms proper, thereby making the delivery rooms available without conflict for the normal cases. The care of a patient in labor is a greater responsibility than the postponement of an operative procedure for an elective case in surgery.

The rapid increase in the number of maternity cases constitutes a hardship not only for the doctor and the patient but also for the hospital personnel. Nurses should be required to do actual nursing procedure only. Aides can be trained to take temperatures, give baths, fold linens and carry out the procedures that are not of a strictly professional order. Charting should be done by clerical workers as much as possible. It has been demonstrated that aides can be trained to care not only for the postpartum patient but also for the woman in labor and the new-born infant. The shortage of nurses makes it imperative to restrict the nurse's work to that which she alone can or should do.

The obstetrician must also do his share to lighten the load. He must be content with less assistance from the intern and the nurse. Interns should not be required to assist with normal deliveries and should not be requested to act as suture nurses. Local anesthesia may have to be employed more frequently in the absence of a sufficient number of trained anesthetists to conduct general anesthesia. The doctor must be content not only with less assistance but also with fewer supplies. Conservation and retrenchment must be the order of the day for the physician as much as for the rest of the personnel.

Hospitals would do well to provide for the future by obtaining as many supplies as possible for the care of obstetrical patients and the new-born. Increases in the activity of the maternity service should be anticipated and adequate provision should be made for them.

Technic Must Be Observed

Despite the increased tempo, care must be taken to maintain a proper technic at all times. It is the duty of the hospital to the community to provide safe and proper service and it is surprising how high the quality of work can be even under apparently adverse circumstances.

Everyone concerned with the problems that arise must realize that these are abnormal times and must attempt to rise to the occasion to the best of his ability. Cheerful cooperation, patient forbearance and ingenuity under difficult conditions are needed today more than ever before. Hospitals can and must meet the present emergency.

Nursing Council Sets Its Sights— 65,000 Students in 1943-44

FLORENCE M. SEDER

SECRETARY, COMMITTEE ON RECRUITMENT OF STUDENT NURSES
NATIONAL NURSING COUNCIL FOR WAR SERVICE, NEW YORK CITY

IN SPITE of Waacs, Waves and high war wages, more than 49,000 young women this year chose to serve their country by enrolling in schools of nursing.

This news is at once good and bad. It is good because the number of new students represents an increase of 11,000 over the peace-time enrollment in 1940, the last prewar year, bad because it falls almost 6000 below the quota of 55,000 set by the federal government for the 1942-43 school year. The recruitment committee of the National Nursing Council for War Service is aware that tremendous effort will be required to meet the 1943-44 quota of 65,000, since competition for the best qualified young women grows day by day. As for the inevitably larger quota for 1944-45, everyone hopes fervently that the war may end before it becomes necessary to enroll them all. Every effort will be made, however, to maintain a steady supply of replacements for civilian services.

Nursing Organizes for War

The leaders of the nursing profession organized for war early in 1941 as the Nursing Council on National Defense. Two months before Pearl Harbor the committee on recruitment of student nurses was formed by the council, as its first committee, to stimulate enrollment of new students. Katharine Faville, director of the Henry Street Visiting Nurse Service, New York City, became its chairman and has continued in that capacity.

For several months this committee made its own plans and gathered material for state recruitment committees, believing that decentralization was the soundest policy. Then came December 7 and the realization that more concentrated attention was necessary. Part-time public relations counsel was employed, and before Christmas letters requesting cooperation were in the hands of deans of women in colleges all over the country and a spring radio and magazine campaign had been planned.

An apparent emphasis upon applicants with some college background may need some explanation inasmuch as many hospital people do not agree upon its value. Leaders and administrators, no less than temperature takers, are needed in the nursing profession. According to some estimates, fully one third of the recruits should be young women with qualities of leadership. College women have a special advantage in that they can be prepared quickly for teaching and supervisory positions. Then, too, because most college women turn to nursing as a career only after careful weighing of its merits, intensive effort is considered essential to their recruitment.

This intensification has not, however, interfered with extensive efforts to recruit a large number of high school graduates. As a matter of fact, complaints have been heard in some areas that the appeals were too general and were bringing inquiries from persons with inadequate preparation.

In the 1942 spring campaign a special radio kit containing spot announcements, anecdotes, interview scripts and factual material was prepared and distributed under its new network allocation plan by the U. S. Office of War Information to networks, local stations and advertising agencies, with a request for free time. Two fifteen minute programs were prepared—written, acted and produced by professionals—and were used by 500 local stations. Magazine publicity began to appear in *Harper's, Occupations, Mademoiselle, Woman's Home Companion, Farm Journal* and other national periodicals. An attractive poster was contributed by the United States Public Health Service.

Inquiries totaling nearly 12,000 in a period of a few weeks overwhelmed the facilities of the nursing information bureau of the American Nurses' Association, and on July 1 this part of its work was taken over by a special clearing bureau established by the National Nursing Council. From July 1 until December 1, 10,149 original inquiries were answered, and 1020 follow-up letters were received and given attention. In addition to replying to specific questions, the clearing bureau sends general information about entrance requirements, vocational opportunities and scholarships and includes lists of state-approved schools in the area from which inquiries come.

Public Relations Stepped Up

Early summer classes accounted for, the matter of fall enrollments loomed over the heads of the recruitment committee. The part-time public relations counselor became a full-time member of the staff and two more persons were added to the public information department.

To assist state recruitment committees, which still carry the brunt of the responsibility, special bulletins have been prepared from time to time giving details of national activities and suggesting local efforts to add to the mass effect. Kits of recruitment material, outlines and reprints have been issued. Occasional releases have been distributed that are filled in by state officers and distributed to the press in their own communities. Cooperation between state and national committees has been close. In the fall, in order to obtain increased aid from local agencies, a public relations manual was prepared for schools of nursing.

Entitled "More Students—How

Schools of Nursing Can Recruit Them," this suggests specifically and in detail how the schools themselves can use to advantage local publicity mediums.

Enthusiastic reception was given to another new recruiting aid that is designed to simplify replies to inquiries and at the same time to meet a growing demand for an attractive, inexpensive announcement for high school bulletin boards. A threefold sheet was contrived; folded, it goes easily into an ordinary envelope and, open, it presents a poster layout, with interesting pictures and a strong presentation of nursing as a profession.

The other side of the sheet is devoted to answering the questions commonly asked by interested young women. "War Work With a Future—Nursing" is the title of the folder. About 50,000 of the 125,000 copies in the first edition have been distributed by the National Council. The rest have been sold at cost to state councils and to schools of nursing for local use. A new edition is on the way.

O.W.I. Gives Its Support

Large scale activities have received active support from the U. S. Office of War Information. Many requests for information have been received from magazine editors and free-lance writers whose interest was stimulated by the O.W.I. Pictures taken by that agency have illustrated articles in a number of national magazines and have inspired still others to take pictures of their own. Newspaper picture editors have made impressive spreads of the O.W.I. pictures or have adapted the subjects to local situations.

The Office of War Information also made possible the recent radio campaign and its tremendous stimulus to public interest in nursing. On the basis of a new collection of spot announcements and other material, 40 national radio advertisers were persuaded to contribute time during the week of December 7 and at least 80 others contributed time during the weeks beginning January 22 and 28. Local stations and chain sustaining programs in unknown numbers helped to keep the need for student nurses in the ears of the radio public around the clock for three weeks.

As a result of this special radio and magazine publicity in December, 9057 inquiries were received. The January radio stimulus swelled the mail to flood proportions—27,947 letters. On March 1 letters were still being received at the special radio address, although in dwindling numbers.

Because earlier publicity had stimulated response from a number of ineligible persons, qualifications were carefully stated in all material released for this campaign and recent inquiries have come in large part from highly eligible young women.

Next Campaign in May

Experience gained in this campaign will, in turn, be put to good use in the next, which was being planned even while this one was on the air. It is scheduled for the first two weeks in May, and the O.W.I. promises it will involve every sort of medium. The American Hospital Association has agreed to turn the spotlight on nursing in this year's National Hospital Day plans, and hospital administrators may expect their activities in that connection to benefit by the national recruitment program since it will open to them sources of assistance that are not usually available.

Another government agency has given steady support to the recruitment program. The U. S. Office of Education has stimulated interest among secondary school administrators and has made several kinds of material available to them. "Professional Nurses Are Needed" is the title of a booklet that tells in detail how suitable young women may be guided into nursing careers. Supplementary material is provided in 75 loan kits for vocational guidance, which contain leaflets, reprints and other material for students to read and discuss. New and more extensive kits will soon be ready. These will add to the present material four transcribed dramatic sketches about nurses and their work (contributed by the subcommittee on nursing); discussion outlines, and suggestions for integrating the subject of nursing into the school program. There is a long waiting list for the present kits, and every prospect that the new ones will be in demand.

Realizing that churches offer an important source of community influence, the council has made efforts to reach them through their national organizations. Articles have appeared in religious periodicals, special services have been conducted for nurses, Nursing Sundays have been celebrated. Further action by local churches should be stimulated.

Other community agencies have given splendid help. Many contacts have been made locally. However, the National Nursing Council for War Service is working with the General Federation of Women's Clubs and the American Red Cross in a broad war nursing program, which stresses among other things student recruitment and the provision of scholarships. More than $35,000 has already been assured.

Similar assistance has come from the American Legion Auxiliary, which voted at its convention to spend $50,000 for personal assistance to student nurses before September 1943. Alpha Phi and Phi Mu, national women's fraternities, arranged last summer to contribute $1000 each toward the nursing education of women with college background. The former has already doubled its fund. Rotary International is participating in both scholarship and recruitment drives through local chapters, and other groups are sharing the work.

Federal Aid Sought

The recruitment committee of the National Nursing Council for War Service works closely with government agencies concerned with nursing, such as the subcommittee on nursing of the Health and Medical Committee and the U. S. Public Health Service. The program of federal aid whch has provided free tuition and other resources to extend educational facilities has, of course, been a cornerstone in the structure. The council has helped to coordinate the thinking of those who believe that additional government aid is necessary for the maintenance of an adequate supply of war nursing service and has made certain recommendations concerning such aid.

Hospital administrators, whether or not their institutions have schools of nursing, are important to the success of student nurse recruitment, just as the success of student nurse recruitment is essential to hospital administration. Their interest and support can lighten the load and speed the day when nursing service will be adequate to meet the new needs created by war and progress.

NOW is the time to offer

Health at Reasonable Rates

R. D. BRISBANE

SUPERINTENDENT, SUTTER HOSPITAL
SACRAMENTO, CALIF.

DALE HARRISON recently wrote in the *Chicago Sun* concerning the $25,000 limitation on salaries, "Quite likely the income of the church, of most forms of culture, of science, of *hospitalization* will be reduced, for these vital phases of our society feed liberally at the trough of incomes over $25,000. Take away from the University of Chicago the millions contributed to it by men of great incomes and you take away without doubt the University of Chicago." (Italics ours.)

Just how will hospitals that now are dependent upon large endowments survive? If the present trend of limitation continues for any length of time, not much more may be expected for charity of any type, and legacies will be the only source of revenue except from the sick themselves. Any inflationary movement whatsoever will erode existing trust funds on which many hospitals and educational institutions largely depend, and it is most unlikely that government control will be sufficient to prevent all inflation unless sterner measures are taken than at present.

The Public Needs a Program

With the present public trend toward tax-supported medicine, about which comparatively little is being done by organized medicine and perhaps not enough by hospitals, a definite program must be offered to the public that will meet its needs and pocketbooks as compared with the present haphazard method of charging for both hospital and medical fees that too often bankrupt the sick or leave them financially crippled for months or years. It is the uncertainty of the cost of illness that is driving the public to distraction and to a search for any relief possible. Most people are willing to pay a reasonable price for anything they buy. But too often the price of health is unreasonable.

A beginning has been made toward meeting this need through Blue Cross insurance, but the maximum has not amounted to more than 20 or 30 per cent of hospital patronage. Saturation point under most favorable circumstances with present rates and benefits will not exceed 50 per cent except possibly in defense activity centers, and that average could not be attained for the country at large or after the war.

For the other 50 to 70 per cent of the population still unsheltered by insurance of any type, other plans must be developed immediately, while the earning power of the country is at its peak, that will ensure health for the large percentage known as the "medically indigent" who can earn a living but cannot pay the extra cost of illness, and that will include the doctor's care as well as hospitalization.

Step No. 1 has been taken toward meeting the public through the agency of Blue Cross with more than 11,000,000 enrolled for hospitalization insurance. This effort must be continued with new types of contracts where they are needed until every self-supporting person in the nation is covered.

Now the time has come for Step No. 2, that is, offering to these 11,000,000 and the millions to follow surgical indemnity insurance. Commercial insurance companies have been offering this for years, evidently with full cooperation of the medical profession which usually accepts their published fees without protest and seems glad to get the checks. Inasmuch as commercial corporations are competing with Blue Cross in every way possible in health and accident insurance, there should be no hesitation in entering a field in which the public and physicians are frequently exploited in order to pay for huge salaries, sumptuous executive offices, large expense accounts and all the other lush accompaniments of overgrown monopolies.

The report of Sir William Beveridge recommending a new social security program for England states that of 103,000,000 policies in force in England in 1939, "premiums received were more than $280,000,000, of which expenses and management took up $96,000,000 while shareholders' dividends amounted to $7,000,000." (*Time,* Dec. 14, 1942.) In other words, 37 per cent of premium money was being spent for expense and dividends! No figures are available for American concerns but most commercial companies are not particularly concerned about keeping down either expense or dividends.

Step Is Worth the Effort

In some states legal steps would need to be taken to enable Blue Cross to write this additional coverage, but any effort will be worth while to forward this necessary move. The risks are known and are as predictable as life insurance, and every Blue Cross plan of any size has plenty of statistics in its files on which to base its premiums. The fees to surgeons can follow local practice, which would also help to determine the premium.

Surgical indemnity insurance now is being offered by two Blue Cross plans in the West and has met with instantaneous and enthusiastic response by the public because the large fees often demanded of the patient by surgeons make him hypersensitive to surgery compared with

strictly medical care that often is paid for by the visit.

State or county medical societies haven't the time or business personnel at their command, except in the larger centers, to enter this insurance field. But the excellent organizations of Blue Cross throughout the United States offer immediate success for any campaign of this kind. All that is needed is legal permission and writing the new policy.

It is gratifying to know that committees of the Hospital Service Plan Commission are hard at work on this problem and may soon have definite constructive suggestions to offer to all of the approved plans.

Finally, as Step No. 3, it is our most carefully considered conclusion after ten years of close association with several and review of all the different types of prepaid health insurance that no satisfactory portion of the public will ever enroll with any insurance plan for payment of nonsurgical medical care unless it is based on the proverbial Chinese method of keeping the individual or family *well* for a stipulated fee.

Obviously, it is unfair to ask the physician to include the wealthy under such prepaid health insurance unless all professions and trades that charge, shall we say, unexpected fees, such as lawyers, undertakers and plumbers, are required to do the same.

Also, it is unjust for a family of two with a $5000 annual income and no dependents to be put on the same basis as a family with the same income and five or ten dependents.

Therefore, we propose, as the only satisfactory method, provision of complete nonsurgical medical care on a quarterly or annual prepaid basis for self-supporting individuals, families or employed groups at or below any fixed *net* income that may be decided as just for the public and the doctor. For such nonsurgical care the fee probably should not exceed $10 per capita annually.

As an example, in a community served by two or more doctors, every person below the highest net income determined would choose his family physician for the quarter or year that payment would cover. The Blue Cross plan would collect from these individuals or groups and mail a monthly check to the doctor covering all collections from the list that chose him, less perhaps 4 per cent for collection fee.

If 1000 persons signed up for Doctor A, the net yield to him after collection would be $9600 yearly, or a check for $800 on his desk at the beginning of each month. Such an income would be five times his usual average, he would be financially independent, his fixed expense for office, nurse and car would be covered and *the public would be satisfied*. In addition, he would have his wealthier clientele and compensation insurance practice. If the county or state would subsidize the medically indigent, or the indigent in some sections, for even a portion of the $10 annual fee, the doctor's income would benefit accordingly. Malingering could be controlled by a 25 cent fee for office or home calls.

The program is immediately available through widespread Blue Cross organizations. The public is clamoring for it. Step 1 has been taken. Step 2 can be taken at once. Step 3 awaits only the cooperation of local physicians.

Uniforms Designed for Action

COMFORT, freedom for action, trim appearance and ease of laundering are the qualities that nurses, food service workers and laboratory workers seek most earnestly in their uniforms—and these qualities are incorporated in the uniforms designed by the U. S. Department of Agriculture's bureau of home economics.

The two outfits pictured below are a nurse's uniform and a food preparation dress. Both uniforms have a full-length opening, which makes them easy to step into.

Freedom for action is stressed in the nurse's dress in the design of the back. Shoulder pleats or gathers are discarded in favor of pleats radiating from the waistline in order to release fullness toward the shoulder blades.

The popular shirtwaist style, short yoke at back and front and a tailored collar, is designed to make the food preparation dress becoming to large and small women alike. To ensure adequate "reaching room" there are gathers across the shoulder, back and front, and insets under the short sleeves.

Among the fabrics recommended for the nurse's dress are spun viscose rayon with crease-resistant finish, shower-resistant broadcloth, seersuckers and poplins.

Seersucker, gingham or chambray are considered suitable materials for the food preparation dress.

The third uniform (not shown) is the laboratory dress, which is designed in wrap-around style, fastening at the back with snaps.

NURSE'S UNIFORM

Bureau of Home Economics

FOOD PREPARATION DRESS

It's the ANGLE *that determines the success of* Hospital News

LENORE R. HEALY
PUBLIC RELATIONS COUNSELOR
BENTLEY AND LIVINGSTONE, INC., CHICAGO

WHETHER your hospital is in a town, small city or metropolis, you must "angle" your newspaper releases in order to obtain the full cooperation of the press. Hospitals must realize that sending stories to the newspapers is not a "hit or miss" game, but a well-planned, minutely thought-out procedure.

What constitutes a hospital news story? The possibilities are endless. Here is a partial list of subjects which, if properly handled, will bring results: new medical equipment, new hospital equipment, changes in administrative staff, changes in professional staff, annual reports, hospital war activity, auxiliary news, celebrated patients and chatty items especially written for columnists.

Let's take the hospital equipment story. From the hospital's standpoint, the release must not only tell of the installation but must show what this piece of equipment will do for the public, mention the safety factors and, above all, include written proof of the hospital's adherence to public health rules. In May 1941, X Hospital, Chicago, installed plastic bassinets in the nursery. This story received nation-wide attention. The wire services, *American Magazine* and the Chicago papers carried not only the story but a two to three column picture of the new plastic bassinet.

This is the story that appeared in the Chicago *Tribune,* May 4, 1941:

"Streamlined bassinets, which are wired for everything but sound, including oxygen, humidity and heating elements, are being installed in the nursery of X Hospital. Made of a transparent plastic material, the bassinets enable parents to watch every movement of their newly born children through the plate glass windows in the corridor which separates the nursery from the rest of the hospital. They are also a greater safety factor in permitting nurses on duty to observe their young charges from any part of the nursery. Whenever necessary, the bassinets can be used as incubators."

This story carried such human interest that people sent in donations to help finance the purchase and installation of the bassinets.

An electro-encephalograph was installed at Y Hospital. This piece of equipment was strictly medical and of a highly technical nature. Chicago papers carried the story and pictures. The Chicago *Daily News* release of June 20, 1941, was as follows:

"Y Hospital has just installed an electro-encephalograph—an electric instrument for measuring the potential of the brain cells, so sensitive that it can measure the energy used in a wink, even if only one eyelid is used.

"Announcement of the new addition to the hospital's diagnostic resources was made today. Housed in a specially insulated and grounded room in the neurosurgical division, it is used to detect and map tumors or injuries occurring in the brain that affect the electric potential of its cells. Its findings are recorded on a three-track tape like that from a stock ticker."

This release is particularly interesting because of its technical nature. It was boiled down into the language of the lay public. The last sentence is a good example of this point. The machine showed the modernity of the hospital and at the same time the points of safety were stressed by mentioning how it was housed. It will be noted, also, that the copy contains mention of a specific department of the hospital.

None of this just happens. These releases were verbatim as sent out by the public relations counselors. The hospitals got a send-off from them, the newspapers got a story and no rewrite job was necessary for the press, so everybody was happy.

When a change in administration takes place at a hospital the announcement must be short and to the point, if it is to get space. X Hospital had a change in administrators and superiors in August 1941. The release was captioned:

HOSPITAL APPOINTMENTS

Two appointments effecting administration changes at X Hospital were announced today when Sister Mary William, R.S.M., was appointed superior and Sister Mary Redempta, R.S.M., was made superintendent to succeed Sister Mary Lidwina, R.S.M., who has occupied both posts since 1935.

All Chicago papers carried the story, the foregoing having appeared in the *Times.* The Chicago *Daily News* of the same date used an even longer story, stating where the former administrator was going and the duties of the new executives previous to their taking office. This type of release definitely lends prestige to the institution because, according to surveys made, the lay public feels that any organization that warrants newspaper attention of this kind must be good.

The war has afforded an opening for a great deal of notice for hospitals. Listings of personnel with the armed forces are always good. In large cities, such as Chicago, the bid for newspaper space is great. As a result, it is much harder to get press cooperation. It can be done, though, if the releases are "angled" correctly.

Always remember the following hard and fast rules when submitting copy to newspapers and the recognition of the press will be yours.

Be honest. Notify all papers in your city at the same time. Never "arrange" a happening before it occurs just to beat another hospital to the punch; this would be poor public relations and put the institution in a bad light with the fourth estate. Cooperate with the press and give it the details it wants. Make your story good, so good editors will want to print it. Never insist upon space just because someone on your board is a heavy advertiser.

SPECIAL DIETS

Are Still Being Served

WAR and rationing have apparently not changed the habits of small hospitals in regard to serving special diets when they are needed. All of the 18 hospitals that responded to The MODERN HOSPITAL's question-of-the-month indicated that they serve some special diets—although the range and variety differ considerably from hospital to hospital, generally depending on the size of the institution and the personnel available.

The round-up of questions and answers is as follows:

Question 1.—What special diets are provided in your hospital?

• All special diets as ordinarily provided in large hospitals, such as diabetic, various prescriptions for ulcers, reduction, high caloric and high vitamin, ketogenic, high and low protein, salt-free, low salt, nonresidue, low residue and other less common therapeutic diets.—CECILLE GAGNON, *dietitian, Miller Memorial Hospital, Duluth, Minn. (83 beds).*

• Routine diets for diseases requiring them. We do not employ a dietitian; therefore, any special diets ordered for particular diseases are taken care of principally by the superintendent or her assistant. Our diabetic cases seem to be our chief concern. —MARTHA M. HOFFMAN, R.N., *superintendent, Edward N. McCready Memorial Hospital, Crisfield, Md. (36 beds).*

• Any that are requested by the medical staff. Diabetic, low protein, low fat, ulcer and weight reduction diets are among those that are most frequently requested in this hospital. —GEORGE P. LYDENS, *administrator, Good Samaritan Hospital, Sandusky, Ohio (60 beds).*

• All special diets ordered by the doctors are provided in this hospital. —MRS. R. C. MARTIN, *dietitian, St. Mary's Hospital, Reno, Nev. (75 beds).*

• Diabetic and nephritic.—SISTER M. AMBROSINA, *superintendent, St. Mary's Hospital, Emporia, Kan. (65 beds).*

• Diabetic, ulcer, gall bladder, cardiac, hypertension, diseases of the kidney, weight reduction and weight increase.—MAURICE STOLLERMAN, *superintendent, Miriam Hospital, Providence, R. I. (63 beds).*

• As specified by the doctors.—PEARL HATCH, R.N., *superintendent, Harrison Memorial Hospital, Bremerton, Wash. (125 beds).*

• Any that are ordered by the physician.—ELLEN C. DALY, *superintendent, Knox County General Hospital, Rockland, Me. (65 beds).*

• All that are requested by the staff. —AUSTIN J. SHONEKE, *superintendent, Litchfield County Hospital, Winsted, Conn. (69 beds).*

• Bland, diabetic, salt-free and high caloric.—LAURA A. HORNBACK, *superintendent, Pike County Hospital, Louisiana, Mo. (50 beds).*

• Diabetic, sugar-free, animal-free, ulcer and fat-free.—MRS. H. GRACE MCCORMACK, *Masonic Hospital, Cherokee, Okla.*

• All special diets. — EMMA M. EVANS, R.N., *superintendent, Community Hospital, Boulder, Colo. (45 beds).*

• Diabetic, nephritic, high caloric, gall bladder and others requested by medical staff.—OTTO F. KELLER, *administrator, Dodge County Hospital, Fremont, Neb. (55 beds).*

• Weighed diabetic diets (calculated), low fat, low salt, low protein, high caloric, high vitamin, ambulatory ulcer, low caloric, low residue, cardiac, Karrell, elimination, bland and low purine. — KATHERINE M. DANNER, *administrator, Mary Imogene Bassett Hospital, Cooperstown, N. Y. (96 beds).*

• Diabetic, low residue, salt-free, bland, peptic ulcer, obesity, purine-free, 1500 caloric, nephritic, high and low carbohydrate.—AMELIA E. DETT, R.N., *superintendent, Community Hospital, Big Rapids, Mich. (41 beds).*

• Any ordered by the doctor. These are usually diabetic, ulcer, low and high protein, high caloric and low fat.—OLIVE M. GRAHAM, *Wausau Memorial Hospital, Wausau, Wis. (120 beds).*

• Diabetic, nephritic, bland, reduction, Sippy, anemia, gall bladder, high carbohydrate, high residue, low residue, gastro-enterostomy, colostomy, cardiac, Scott and Ivy formula, Muelengracht, high vitamin and high calcium.—LOTTIE M. REED, *dietitian, St. Luke's Hospital, Pasadena, Calif. (145 beds).*

• Low caloric, bland, low residue,

diabetic, high vitamin, Sippy, fat-free and salt-free.—ESTHER KINER, *dietitian, Geneva Community Hospital, Geneva, Ill. (85 beds).*

Question 2.—What list of special diets or what source book is consulted in planning these special diets, or are they specified by the medical staff?

• All special diets are ordered and usually specified by the doctor, with occasional consultation with the dietitian. Sources of information include diets from various hospitals and universities. These are compiled by the dietitian and placed in a permanent file for the hospital. Textbooks and recent periodicals are also used.—*Miller Memorial Hospital.*

• Diets are specified by the medical staff, but we rely a great deal on the publications issued by Eli Lilly and Company in calculating diabetic diets.—*Edward N. McCready Memorial Hospital.*

• The New York Hospital "Handbook of Applied Nutrition" and "Compilation of Diets," by the California Dietetic Association.—*Good Samaritan Hospital.*

• The type of diet is specified by the doctor and the dietitian plans the diet. A few of our reference books are: "Chemistry of Food and Nutrition," Sherman; "Practical Dietetics," Pattee; "A Dietary Computer," Pope; "A Handbook for the Diabetic," Rowe, and "Laboratory Handbook of Dietetics," Mary Swartz Rose.—*St. Mary's Hospital (Nev.).*

• For diabetics the medical staff specifies mostly from a book edited by Eli Lilly and Company.—*St. Mary's Hospital (Kan.).*

• "Handbook on Diet and Disease," Pattee; Mount Sinai Hospital "Handbook"; "Manual" of Eli Lilly and Company, and "Handbook on Diet," Mary Swartz Rose.—*Miriam Hospital.*

• Information on diabetic diets and feeding of ileostomy cases is obtained from the Virginia Mason Hospital, Seattle, and on eclamptic diets from St. Louis Maternity Hospital.—*Harrison Memorial Hospital.*

• Diets are ordered by the medical staff.—*Knox County General Hospital.*

• Specified by staff.—*Litchfield County Hospital.*

• Our medical staff and "Treatment by Diet," (fourth edition) by Clifford J. Berborka, M.D.—*Pike County Hospital.*

• "Nutrition and Diet Therapy," Proudfit.—*Boulder Community Hospital.*

• Special diets are specified by the medical staff.—*Dodge County Hospital.*

• They are specified by the medical staff.—*Mary Imogene Bassett Hospital.*

• We use all special diets used at the Henry Ford Hospital in Detroit and also those selected and made up by our medical staff.—*Big Rapids Community Hospital.*

• "Manual of Diets," University of Iowa; "Manual of Diets," E. J. Sevringhaus, M.D., University of Wisconsin, and "Nutrition in Health and Disease," James S. McLester, M.D. —*Wausau Memorial Hospital.*

• Our source books are: "Diet Therapy," Proudfit; "Applied Dietetics," Frances Stern, and "Laboratory Handbook of Dietetics," Mary Swartz Rose. Gastro-enterostomy, high vitamin, high calcium and Muelengracht diets and the Scott and Ivy formula are specified by the medical staff.—*St. Luke's Hospital.*

• We have a compilation by the dietitian which is changed as new information is acquired. The members of the medical staff sometimes have ideas that are carried out with a particular patient.—*Geneva Community Hospital.*

Question 3.—What person in the hospital organization computes, weighs and checks the diets?

• The dietitian computes and checks the diets, charts all diabetic diets and visits and instructs the patients. A lay person prepares and weighs the food under the supervision of the dietitian.—*Miller Memorial Hospital.*

• Superintendent or assistant superintendent.—*Edward N. McCready Hospital.*

• The diet kitchen maid weighs the diets and they are then checked by the dietitian.—*Good Samaritan Hospital.*

• The dietitian.—*St. Mary's Hospital (Nev.).*

• The floor supervisor.—*St. Mary's Hospital (Kan.).*

• The dietitian.—*Miriam Hospital.*

• The floor charge nurse.—*Harrison Memorial Hospital.*

• The dietitian.—*Knox County General Hospital.*

• The dietitian.—*Litchfield County Hospital.*

• Assistant superintendent of nurses. —*Pike County Hospital.*

• The head nurse on the floor.—*Masonic Hospital.*

• The dietitian.—*Boulder Community Hospital.*

• The floor supervisor computes the diets and the tray girl weighs and checks them.—*Dodge County Hospital.*

• The dietitian.—*Mary Imogene Bassett Hospital.*

• The assistant superintendent who has full charge of the kitchen, diets, meal planning, buying of foods and stockroom.—*Big Rapids Community Hospital.*

• The dietitian computes and checks and the diet kitchen helper (a high school graduate) weighs and serves. —*Wausau Memorial Hospital.*

• The head dietitian.—*St. Luke's Hospital.*

• The assistant cook weighs and prepares food for special diets and they are weighed and checked by the dietitian.—*Geneva Community Hospital.*

Question 4.—Do you make an additional charge for any or all of the special diets? If so, what are some representative charges?

With only two exceptions the responding hospitals stated that no charge is made for serving special diets. Of the two that do make such a charge, Geneva Community Hospital reports that 50 cents per tray is assessed for weighed diets, such as diabetic and ketogenic. The second institution, St. Luke's Hospital, charges $5 for making up a formula, such as the Scott and Ivy, when it is for out-patients.

Speaking for State Hospital Boards

ESTHER M. LEE
MEMBER, BOARD OF TRUSTEES
NORRISTOWN STATE HOSPITAL
NORRISTOWN, PA.

ALL trustees, I presume, have fairly definite ideas as to what is good for the institution they serve and the communities in which they are placed. Sometimes ideas become so definite and so fixed that our minds are in danger of becoming closed to ideas that may be as good as ours. A little introspection now and then won't hurt any of us.

It is essential that the duties and responsibilities of a citizens' board should be sharply defined by law. Included in the Pennsylvania Administrative Code concerned with boards of trustees are these provisions:

Board Appoints Administrator

Sec. 2318. The board of trustees of each state institution within the department of welfare shall have general direction and control of the property and management of such institution. It shall have the power and its duty shall be (a) subject to the approval of the governor, to elect a superintendent or warden of the institution, who shall, subject to the authority of the board, administer the institution in all its departments; (b) on nomination by the superintendent or warden, from time to time, to appoint such officers and employes as may be necessary; (c) to fix the salaries of its employes in conformity with the standards fixed by the executive board, and (d) subject to the approval of the secretary of welfare, to make such by-laws, rules and regulations for the management of the institution as it may deem wise.

Section "b" "on nomination by the superintendent . . . to appoint such officers and employes as may be necessary" is interpreted differently by different trustees. My belief is that the employment of personnel is the superintendent's duty and responsibility. We of the board should be consulted by him, particularly as to the professional staff, and it is our duty to look carefully into the applicant's fitness for the job, but the nomination should be made by the person we have selected to head the institution and great weight should be given to his choice.

"To the victor belongs the spoils" should never be a part of a trustee's philosophy in connection with institutions in which we are endeavoring to care for and to cure people, helpless and unable to speak for themselves. For their care we should employ the best staff possible without regard to party affiliation. It is not advocated that we go out of our way to employ or retain one of the minority party, but where the decision should be based on fitness for the job, there should be no question that the qualified person should be employed or retained.

The men and women who have devoted their lives to the service of our institutions and those of us who have close contact with these institutions can bear witness to the chaos within the hospitals and within the community, too, that is created by the so-called political control of the employes.

The merit system of employment, commonly called civil service, seems to be the best solution of the problem. Recently, the head of one of our institutions said he would hate to "freeze in" the type of employe he is obliged to hire these days. Surely we agree with him, but isn't it wrong to assume that a civil service program cannot be developed during the war period? Institutions that have civil service protection would be more likely to recruit good staff members because they would be assured of some protection on the job as long as they render faithful and efficient service.

An excellent method of developing the present staff is through an in-service training program. The public service institute of the Pennsylvania Department of Public Instruction is giving in-training courses. Firemen, policemen and workers in penal and correctional institutions have taken the courses and it has been surprising how well staffs have developed through this training. It might be well to investigate this plan which the state offers to train public employes.

At present, courses for attendants, leading to certification, are being given at two of our state mental disease hospitals; orientation courses consisting of a minimum number of lectures are given in our larger hospitals. Two of our institutions conduct nurses' training courses. Nevertheless, an in-service training course as offered by the public service institute would provide a unified training system for all the institutions and bears investigation. In the meantime we should work for a civil service law and try to convince our legislators of its value. Some of them have expressed themselves as favoring the system for our hospitals.

Salaries Need Adjusting

Tied closely with the question of employment lies that of adequate pay and sufficient appropriations from the legislature to ensure efficient management of our institutions. Our poorly paid staffs are leaving us for larger salaries to meet present day living costs. In spite of the fact that increases have recently been granted, should we not assume

*Abstracted from a talk before the semi-annual meeting of the Association of the Trustees and Medical Superintendents of Pennsylvania State and Incorporated Hospitals for Mental Diseases and Defects.

the responsibility of obtaining a substantial salary scale revision all along the line?

Insofar as the institutions' upkeep is concerned, it is our duty as trustees to impress on our senators and representatives their responsibility for seeing that proper allocation of funds is made to ensure the maintenance and, better still, the improvement of standards of care. Most of us on boards of trustees have opportunities to speak to citizen groups in behalf of our institutions and the public should be informed of our problems.

Another of my duties, and a pleasant one, is attendance at board meetings regularly in order that I may fulfill my responsibilities intelligently. The visiting committee appointments enable us to become acquainted with the physical upkeep of the hospital and the problems in this field. Here, too, we have the responsibility of making constructive suggestions for improvement.

An important and often neglected duty is that of interpreting to the community the services rendered by our institutions. The clinics we conduct in the hospital areas are little known outside the circle they serve. We have a responsibility also in trying to break down the still existing fear of what is known as the "insane asylum" in many communities. People who have no hesitancy in sending a member of their family to a tuberculosis sanatorium feel it is a disgrace to send a loved one to a hospital for the mentally ill. We can do a great deal to break down this feeling by spreading the gospel of the kind of care and treatment we are giving today.

In order to ensure a more efficient and smooth-running institution we should have staggered terms for members of boards of trustees. To expect under the present Pennsylvania law that even a few members be retained when an administration changes is perhaps asking a great deal of a governor, but if the law were amended to read as it did in 1923 there would be a chance of continuity of administration. In 1923 the law read that "of the first members of each board appointed three shall be appointed for two years, three for four years and three for six years."

In 1927 it was changed to read, "The terms of the members of each such board shall be four years and until their successors are qualified, provided that of the first members of each such board five shall be appointed for terms of four years and four for terms of two years." In 1929 the law was again amended to read, "The terms of the members of each board shall be four years and until their successors are qualified." And so it stands today.

It should not be difficult to promote the understanding that boards of trustees are a means of safeguarding not only the interests of the unfortunate people in our care but the resources of all of us from partisan politics. Under a staggered basis of appointment we will have better board material. There is no justification for setting up boards that are mere rubber stamps. Generally speaking, the more that is demanded of a board member the better the type of person who can be persuaded to undertake the responsibility that membership entails.

Given conscientious and experienced trustees and the right kind of a superintendent, good administration of our institutions is assured. And this should be, and is, our objective.

WOMEN'S SERVICE GROUPS

Replacing 42 Employes

Just try to fill the jobs of 42 full-time workers these days, meanwhile maintaining an inner calm. Hartford Hospital, Hartford, Conn., has filled that many jobs on the wards and in the office and Dr. Wilmar M. Allen, the director, writes of these changes calmly, if a bit pridefully.

In a city with great war industries, Doctor Allen and his administrative staff have filled these 42 jobs in the only way so many jobs could be competently filled in these times—by the part-time services of some 400 women volunteers.

The Hartford Hospital Volunteers celebrated their first anniversary as an organization in January. Hospital staff and patients affectionately call these women the Blue Birds, so apparently they bring happiness to both management and clientele.

Not to be completely outclassed by the women's Four Hundred, headed by Mrs. Charles P. Stewart, a group of men, who had completed a Red Cross first-aid course last July, organized under Paul M. Butterworth as volunteer Medical Aids.

Mrs. Mitchell S. Little, meanwhile, has been signing up more and more recruits and graduates from the Red Cross nurses' aide courses.

A fourth volunteer chairman, Mrs. Henry C. F. Howell, directed the turning out of 690,675 surgical dressings last year. Forty-four branches assisted. The cutting for these dressings was done by the Hartford Junior League.

It would be too bad to leave Hartford Hospital without mentioning its beautiful new South Building, the five floors of which were decorated by another women's auxiliary committee headed by Mrs. Walter Roberts. It also chose the new china and silver.

Nor can we resist mentioning, although it isn't strictly W.S.G. stuff, that Hartford Hospital learned to its surprise at the last A.M.A. census that it is, by admissions, the largest nongovernmental hospital in the country. The women are working even harder since they found that out—local pride, no doubt.

In an Alcove

The Alcove Shop, they call it at Jefferson Hospital, Philadelphia. The social service committee of the women's board maintains it and the proceeds provide for the purchase of surgical appliances for patients. Last year 349 persons received appliances, either as outright gifts or on a loan basis.

Founds Convalescent Farm

This successful small shop is a relatively insignificant contribution to Jefferson Hospital's service compared to another project of the social service committee. That is Ivycroft Farm, a convalescent home for men patients located at Wayne, Pa.

All hospitals in the city may send men convalescents to Ivycroft where they receive scientific care until they are able to return to their jobs and families. So broadly conceived is this institution that its doors are open not only to hospital patients convalescing from illness or injury but also to men in poor health who are not sick enough to enter a city hospital. As one can imagine occupational therapy plays a large part in the daily routine at the farm.

Ivycroft is close to the city and is on a bus line and a good highway. The social service committee's motor messenger service, the means by which staff visits were paid to the farm and to patients' homes, had to be discontinued when gas rationing was decreed. However, a women's board member solved the transportation problem by purchasing a car for the use of the social service staff.

UNICAP* VITAMINS *at a New Low Price!*

Nutrition is not the only factor in health and morale, but it is the most important one.

—*The National Research Council*

Now that food is being rationed, it is more necessary than ever that the physician keep close watch over his patients' diets. Economical Unicap Vitamins plus the average diet supply all the important vitamins.

ONE UNICAP A DAY PROVIDES

Vitamin A	5,000 U. S. P. units
Vitamin D	500 U. S. P. units
Ascorbic Acid (Vitamin C)	10.0 mg.
Thiamine Hydrochloride (Vitamin B_1)	1.5 mg.
Riboflavin (Vitamin B_2, G)	2.0 mg.
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Nicotinic Acid Amide (Nicotinamide)	20.0 mg.

Available at your prescription pharmacy in bottles of 24 and 100

A 20% PRICE REDUCTION became effective February 9, 1943

Another Way to Save Lives Buy War Bonds for Victory

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FINE PHARMACEUTICALS SINCE 1886

*Reg. U. S. Pat. Off.

Where to Find—and How to Keep *The Elusive Laundry Operator*

I. G. GARCELON
DEPARTMENT OF PRODUCTION AND ENGINEERING
AMERICAN INSTITUTE OF LAUNDERING, JOLIET, ILL.

THE most serious problem that the laundry department is facing today is the reduced supply of labor and it will probably become more and more acute as the war program cuts into the available manpower.

The war plants, which are our chief labor competitors, require of women workers that they be between the ages of 18 and 45 years and citizens of the United States with no police or jail record in their immediate families.

One thing we should do, then, is to hire younger or older operators who are not subject to war jobs. I have seen several plants that have hired deaf operators and even deaf and dumb people. These people make excellent workers after they have been properly trained, although they are harder to train originally. In departments in which talking may cause errors these operators do a splendid job.

Negroes Are Good Workers

Some white operators look down on laundry jobs while colored help looks up to them. Contrary to some laundrymen's beliefs, the experience of our field engineers shows that colored workers will produce just as much as white help if they are properly trained and supervised.

Many foreign-born people who have not established their citizenship can be employed in laundries.

In most communities we can find quite a few women who are unable to work full time but who would be glad to accept employment for a few days each week. These women do not come under the classification for war industries. Two part-time operators may equal one full-time operator. Of course, this is not an ideal setup, but it has possibilities in a serious pinch.

How can we get in touch with these people? The United States Employment Service is in contact with a great many people who cannot be employed on war work but who would make good laundry operators.

At one laundry a list of openings in the plant is posted on the bulletin board each night. Operators are paid $2.50 for bringing in a new employe if she stays two weeks, $10 if the new employe is still working at the end of three months. Thus, the present operators sell the laundry to their friends as a nice place to work. They also take a personal interest in the new employe for at least three months until she gets established. The plan works.

Deaf and handicapped workers can best be reached through the schools and associations for deaf and handicapped people. The intelligence of these workers in most cases is higher than the average.

The best type of colored worker can usually be located through pastors of colored churches and teachers of vocational schools, and most of them are more than glad to cooperate.

In most cities the foreign-born have their own sections and churches and they can be reached through their pastors and employment agencies in those districts.

Most part-time workers will be local people and can be found locally through employes or by signs.

How are we going to keep applicants after they arrive at our plant looking for a job? Are our personnel policies streamlined to compete with our competitors in the labor market.

Do we have someone designated to interview the new applicants who is thoroughly familiar with our labor requirements? New applicants should be interviewed promptly and, if satisfactory, should be hired promptly so that they do not have the opportunity to drift into other jobs.

Introductions Are Important

After we have hired the applicant, it is best to have some qualified person delegated to acquaint the new employe with plant routine—the space allotted her in the locker room, the regulations with respect to hours and the time clock, the routine regarding uniforms, if any—and to see that she is introduced by name to her supervisor.

All of us realize how difficult it is to obtain experienced operators. In fact, sometimes it is difficult to get even inexperienced operators. It is necessary that we train our new operators quickly, so as not to upset our schedules and so that we can cut down our labor turnover and keep our employes loyal.

An article in the July issue of *Factory Management and Maintenance,* entitled "Get Ready Now for Manpower Control," says: "Management must then get set for the day when it may have to prove to government plant inspectors that it has upgraded and utilized skills to the highest limit, that it has exhausted reserve types of local labor (women, Negroes, older workers,

Presented at the War-Time Laundry Clinic, St. Louis, October 1942.

Just another week in the life of a Hoffman Hospital Representative

Monday.....

"Received a wire from ..... Hospital. Their laundry washman has been drafted, so I rushed over and ran their washroom until they could get another."

Tuesday....

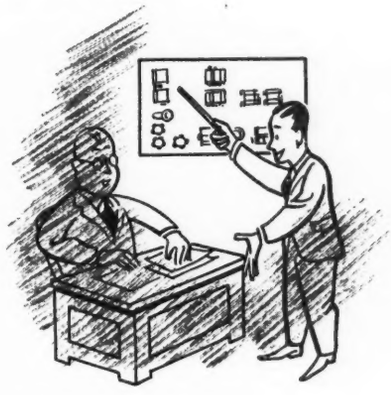
"The new man showed up today, so I spent the day breaking him in on our equipment. He was amazed at the amount of work our Shell-less Washer will turn out."

Wednesday..

"Stopped by ..... Hospital. Showed the Superintendent our new linen control plan. He was quite impressed and called in the housekeeper to listen."

Thursday...

"Saw Mr. ..... the engineer at ..... Hospital. I gave him the Instruction Manuals and Lubrication Charts for our machines that I promised him last week."



Friday.....

"Visited ..... Hospital and explained our recommendation for new work flow plan that will enable them to turn out a bigger volume of work with their present help."

Saturday..

"Went to ..... Hospital. They are getting along fine. No trouble with equipment. Made plans for next week. Our customers sure appreciate these calls."

handicapped workers, certified aliens), and that it maintains an *in-plant training system equal to minimum government requirements.* All this to get any preference in labor supply at all."

This article speaks of upgrading of employes. Upgrading means moving old operators up the ladder to more desirable jobs as openings occur.

Upgrading has not been generally used in the laundry industry because management has not wanted to take the time or trouble to train two operators when, by hiring a new girl for the opening, only one operator needed to be trained. This shortsighted policy has caused much unnecessary labor turnover.

It should be part of the personnel policy to assign new employes to the less skilled and lower paid jobs, with the understanding that they will be granted an opportunity to train for the more desirable jobs when workers are needed.

Such a policy adds to the number of operators who are skilled in more than one operation, serves us in an emergency and also prepares operators to become department heads.

To obtain maximum production throughout the day, we must have a definite policy to combat fatigue. It is a well-known fact that the most effective way of combating fatigue is to prevent it.

Our field engineers have inaugurated rest periods in a number of laundries throughout the country, and in every case production has increased.

Ten Minutes' Rest Allowed

In our own Institute laundry, we allow two ten minute rest periods a day—one in the morning and one in the afternoon.

In the case of a new operator, the greatest source of fatigue comes from inexperience and the more we do to reduce the fatigue, the better chance we have of keeping the new operator.

Some states have laws requiring mats or platforms in front of machines or tables at which operators stand all day on concrete floors to reduce fatigue.

If the new operator comes to work in dancing slippers or rubbers, the supervisor doing the training should tactfully suggest that the new employe try more comfortable shoes to reduce fatigue. The supervisor can then point out the advantage of the proper kind of footwear and the fact that it can be purchased through the laundry and paid for through a pay roll deduction plan. An institution that does not have a plan of this kind might do well to investigate its possibilities.

Another source of fatigue to new operators is noise. Some plants seem to be a bedlam of noise with operators yelling to other operators, belts squeaking and machinery not in good repair. I have known new employes to quit because they just could not stand the noise.

By this, I do not mean that we should put up big signs warning employes not to talk. When there is excessive yelling in a plant, it is usually necessary because the system of work through the plant is faulty somewhere; no doubt it can easily be corrected.

Many operators are willing to accept less money if the laundry is well equipped and clean and if the surroundings are congenial.

First, a laundry's major job is to sell cleanliness. With the press of production problems and the shortage of labor, the cleanliness of the department is likely to suffer first. New operators are particularly impressed if they find themselves working in a clean place, so floors, stairways, building and equipment must be kept free from dirt, lint and litter by frequent cleaning.

I cannot stress too strongly the importance of having cheerful, clean and sanitary toilets, dressing rooms and restrooms for both sexes.

Individual lockers should be provided for the employes to use for their street clothes and personal effects instead of having them hung all over the plant and strung around the work area.

Chilled drinking water at convenient locations should be furnished, with salt tablets available over each fountain to minimize fatigue and heat prostration during hot weather.

A thorough study of the problem of ventilation will disclose ways in which the discomfort that is traditionally associated with the laundry during hot weather can be materially reduced.

Air has a cooling effect, even if it is hot, as long as it is kept in motion. Fans can and should be placed so that all areas in the laundry have sufficient air movement. By this I do not mean that they should blow directly on the operators.

Hoods can be erected over flatwork ironers to carry off a great deal of hot, humid air, making it possible to control ventilation better. Metal for these hoods is almost impossible to obtain at the present time, but effective hoods can be made of plywood.

In winter, all sections of the department should be properly heated so that some operators do not have to work in coats while others are too warm.

With reduced labor turnover, the number of complaints will be reduced. Normally, complaints are caused by a multiplicity of small details that are missed throughout the operations performed on the clothes as they are processed. These errors can be traced to new employes who are not familiar with the operations, management that is not training its employes properly or employes who are slipping because of insufficient supervision or incorrect methods.

ENGINEERS' QUESTION BOX

Replacing Elevator Cables

Question 6: Who determines (and on what basis) how often elevator cables should be replaced?—R.E., N.Y.

ANSWER: The insurance and city inspectors determine when elevator cables need replacing.—LELAND MAMER, *Evanston, Ill.*

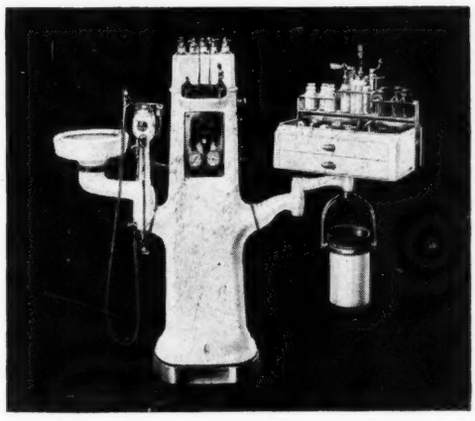
Tester Removes Guesswork

Question 36: What is the best way of testing lamps, ballast coils and starting switches on our fluorescent lighting fixtures? —J.B., Me.

ANSWER 1: New information is being accumulated daily regarding the operation of fluorescent lamps. I would suggest that J. B. purchase a tester that removes guesswork in testing fluorescent fixtures, bulbs, starters and ballasts. With this instrument it is no longer necessary to remove a fluorescent fixture from the ceiling to determine what is wrong. There is no guesswork. In two minutes you have the answer.—OSCAR E. OLSON, *chief engineer, Wisconsin General Hospital, Madison, Wis.*

ANSWER 2: I advise J. B. to write to the General Electric lamp department for the pamphlet "Check List

Saves Time in Busy Clinics...



The gleaming, streamlined beauty of a modern Ritter ENT Unit will add greatly to the beauty of your clinic and out-patient departments.

Many a hospital clinic, faced with a shortage of physicians, has installed Ritter ENT Units to relieve the pressure on the men who remain on the staff.

Because these compactly designed Units group every examination, treatment and operating essential within less than arm's reach—and—because all are actuated by finger-tip control, they enable a specialist to serve more patients in less time with an absolute minimum of operative fatigue.

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Ritter Company, Inc., Rochester, N. Y.

Ritter *Ear, Nose and Throat Unit*

on Fluorescent Lamp Operation," which covers this question thoroughly. —DAVID PATTERSON, *chief engineer, West Suburban Hospital Association, Oak Park, Ill.*

Composition for Valves

Question 39: In view of the rubber shortage, I am worried about replacing the dump valves on our laundry washers. Is there anything I can use in place of rubber?—R.C., Ark.

ANSWER: Manufacturers are making a composition to replace rubber.—DAVID PATTERSON, *chief engineer, West Suburban Hospital Association, Oak Park, Ill.*

Freon, Ammonia Lines Leaking?

Question 25: What tests should I use for leaks in the ammonia line? For leaks in freon lines?—L.M.W., Iowa.

ANSWER: To test for ammonia leaks in lines use a sulphur candle and go over every joint all around the pipe carefully. If a leak is present, the sulphur candle will produce a thick white smoke when it comes in contact with ammonia.

Another method for testing is the use of phenolphthalein paper which changes color instantly when coming in contact with ammonia.

To test for freon (F.12) leaks use a heavy soap solution and paint all joints. If leaks are present, the soap solution will form bubbles.

In addition, it is possible to use an alcohol lamp (halide type) with a long rubber inlet tube to get around the large pipes. Pass the tube over every joint. If a leak is present, the flame from the lamp will be a brilliant green.

If pipes are covered, such covering must be removed at all joints, fittings and valves to be tested. If this is not possible, cut a piece about 3 inches long from the casing at the joints and replace it when the test is finished.—E. W. RIESBECK, *consulting and construction engineer, Chicago.*

RIESBECK RECEIVES AWARD

E. W. Riesbeck, Chicago consulting engineer, was selected to receive the Question Box award of $5 in March for his answer to the question: "What Causes Newly Sterilized Dressings to Mildew?"

Value of Wall-Washing Machines

Question 8: With sponges now selling at about $15 a pound, would this be a good time to use wall-washing machines?—N.T., Mass.

ANSWER: Yes, it would, although there are still places where a sponge is more adaptable than is the machine.—LELAND MAMER, *Evanston, Ill.*

HOUSEKEEPING PROCEDURES

Conducted by Alta M. LaBelle

Cleaning Upholstered Furniture

Keeping upholstered furniture in good condition is one of the many problems that confront the harassed housekeeper. Good maintenance involves the prompt removal of all spots and stains and a general all-over cleaning from time to time.

The best and safest method of cleaning upholstering, in the opinion of Mrs. Ivah Allen, housekeeper at Blessing Hospital, Quincy, Ill., is, first, to remove all loose dirt with a vacuum cleaner. Cushions should be beaten with a switch or carpet beater and dust and dirt should be wiped off with a clean damp cloth. Special care should be taken in cleaning the seams in the fabric. It is advisable to remove spots and stains with a solvent.

The next step is to apply neutral soapsuds with a stiff brush, being careful not to soak the back of the fabric.

Coated fabric or genuine leather should be sponged with a neutral or saddle soap and then wiped with a damp cloth. If this process is repeated several times, the surface dirt will be removed. Cleaning solvents should not be used on coated cloth or genuine leather. The surface should be rubbed with a good oil, such as olive or castor oil, to prevent the leather from cracking.

• •

Building Up Neutral Soap

It is well known that a neutral soap, *i.e.* one in which just sufficient alkali is used to saponify the fatty acids, has comparatively little effect on many types of dirt and soil. Only when an efficient builder is used can soap action be brought to its highest level, and it is necessary to add an alkali "soap builder." The addition of the alkali, it is pointed out by Mrs. Allen, increases the suds and makes one pound of soap do "more and better work."

Neutral soap, Mrs. Allen states, should not contain more than 0.2 per cent of free alkali and its use should be reserved for woolens, fine fabrics, furniture, leather and clothing.

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When to Wax Floors

With hospitals crowded to capacity it is a problem to schedule the cleaning and waxing of floors at a time that is convenient for everyone. At Mac Neal Memorial Hospital, Berwyn, Ill., Orpha Daly, the housekeeper, prefers to have this work done at night.

"There is comparatively little traffic in most parts of the hospital at night and many departments are closed entirely. This allows the worker to clean unmolested and the danger of someone's slipping or falling on newly waxed floors is minimized.

"In the patients' rooms the floors are waxed when the room is vacated unless the patient is in for a long period, then the maid has to do the floor at a time that is most convenient for the patient and the nursing staff."

• •

Save Those Floor Machines

Production of floor sanding, finishing and maintenance machines after April 15 has been prohibited by the amendment on January 16 of Order L-222. That order means that from now on the slogan in the housekeeping department as far as floor machines is concerned will be "Conserve or do without!"

From a manufacturer of this type of

equipment come the following helpful suggestions regarding the proper care of floor machines and brushes:

1. **Housing and Base**—Handle machines carefully. Avoid bumping them against metal radiators. This not only scars the base and motor but sometimes cracks the motor housing or base casting.

2. **Wheels**—As a rule, the wheels of floor machines are used only for moving them from room to room, but wheels are important parts of the equipment and cannot be purchased without priority ratings because most of them contain rubber. Therefore, don't turn on the current when the wheels are on the floor. To do so may cause serious damage to either one or both of the wheels. Wipe the wheels clean immediately after scrubbing. It is a good idea to apply a coat of bright drying wax to the wheels to help in keeping them clean.

3. **Cord**—Don't "whip" the electric cord or cable around to get it out of the way. Whipping makes sharp bends which break down the wires, as well as the cable itself. If the cord becomes tangled or caught around the corner of a desk or other piece of furniture, take a little more time and untangle it gently. Don't give it a "yank."

During the scrubbing process, the cord usually gets wet. Always wipe it off when the job is finished, and keep it waxed, too.

Almost every machine has a cord hook for holding the cable when the machine is not in use. Use it instead of piling the cord around the machine. Someone might step on the socket plug and damage it—and plugs, too, are difficult to obtain.

4. **Brushes**—Do not leave the brush on the machine when it is not in use. The weight of the machine will flatten one edge of the brush, or the brush itself might "freeze" on the attachment from rust and gummy dirt. The brush should be removed and placed bristle side up. The brushes should also be cleaned immediately after use. The bristles will straighten out as they dry and their serviceability will be considerably prolonged.

5. **Cleaning**—After the scrubbing operation, the chromium parts should be rubbed with a small amount of kerosene and wiped dry. This treatment should be given to all exposed parts of the machine, including the under side where brushes are attached.

• •

Housekeeper's Rôle in Building

The prospects of building a new wing or even remodeling the existing structure may seem pretty remote at the moment, but the time will undoubtedly come when many hospitals will be thinking in terms of building—and housekeepers must be ready to contribute their ideas and suggestions.

Mrs. Ivah Allen, housekeeper of Blessing Hospital, Quincy, Ill., believes that before the plans are completed they should be submitted to the housekeeper, as well as to all other department heads. After all, she points out, those who are directing the work of the various departments are in the best position to know the amount and type of space that will be needed and the best location of such areas as storage closets, linen rooms and utility rooms.

As to the housekeeper's rôle in the interior decoration of the structure, much will depend upon her ability, experience and background and on whether she displays good taste in selecting and blending colors. It is Mrs. Allen's feeling that the housekeeper not only should study carefully the institution in which she is employed but should visit other hospitals.

What part the housekeeper will play in purchasing furnishings and equipment will depend largely upon the organization of the institution. In some hospitals the housekeeper does much of the purchasing of furnishings under the supervision of the administrator; in others, she has little to do with it.

Psychiatry turns to the dietitian to aid recovery through the

Enjoyment of Good Eating

LEETA HOUSER

DIETITIAN, MENNINGER SANITARIUM
TOPEKA, KAN.

THE principal aim of all food therapy in a psychiatric hospital is to obtain for the patient a state of good nutrition. In doing this, it is necessary to remember that the eating of food is one of the great universal human pleasures, subject to impairment, distortion, inhibition or total loss, and also to enhancement and exaggeration. To minister wisely to the psychological needs inherent in the taking of food is in many cases just as important as attention to nutritional needs.

The accomplishment of these two aims is the task of the dietitian, guided by the general principles of dietetics and psychiatry on the one hand and by special indications in the individual case on the other.

New Viewpoint Is Essential

Administrative and therapeutic responsibilities of the dietitian in a small psychiatric hospital are identical with those that would be given her in a general hospital of like size. However, in carrying out her responsibilities as a therapeutic dietitian, she soon realizes that a change in point of view, emphasis and approach is necessary. Her concept of illness must be enlarged to include that in which psychological symptoms predominate, or even cause physical symptoms. In short, she must become oriented within the field of psychiatry and obtain the psychiatric point of view.

The administrative responsibilities include such everyday objectives as quality food (definitely measured in terms of the budget), good preparation, variety and attractive service.

Abstract from article published in the Bulletin of Menninger Clinic 6:117 (July) 1942.

At the Menninger Sanitarium, Topeka, Kan., these objectives assume unusual importance. Why? Because the food standards of the institution itself are high, because the management and the medical staff want every patient and employe to be satisfied with the food, because the patients know and are accustomed to good food, because our patients are here for months and sometimes years and because they have the privilege of giving short orders, by which we mean the ordering of food other than that on the daily menu.

Good food well prepared, variety of menu, appetizing color combinations and attractive arrangement of food on the plate, all play an important part in giving the patient satisfaction.

Tray service is necessary for many patients who are not bedridden. Trays are ordered for patients with a tendency to impulsive behavior of a destructive nature, for those who are overstimulated by group activity, who are talkative or irritable, who require extensive supervision, who have difficulty making decisions or whose attention is easily distracted.

In dealing with feeding problems, the experience of the dietitian in a psychiatric hospital differs greatly from the experience of a dietitian in a general hospital. There, if the problem is one of insufficient food intake to maintain adequate nutrition, the solution usually is found by catering to the likes and dislikes of the patient. On the other hand, if the problem is one of excessive food intake, the solution is to put the patient on a reduction diet. We have both of these problems in a psychiatric hospital but the solutions are more difficult because the causes involve the total personality.

In a psychiatric hospital, if a patient refuses food or eats little, such refusal may be directly referable to his delusions of unworthiness or to a delusion that the food is poisoned or to the fact that he is too excited to be aware of the food served to him. In the solution of such problems, the dietitian tries to appeal to the appetite by making the trays as attractive as possible and the servings small. A pretty fruit plate has been used successfully in such an effort. However, the nurse is the important figure in the solution because of her continuous contact with the patients.

With her knowledge of nutrition and her understanding of the motives and mechanisms of behavior, she will recognize eating responses tending toward inadequate nutrition and will seek opportunities to improve such responses. No list of special technics can be given because each case is different and requires that the nurse's method of conduct be individualized.

Nurse Must Establish Rapport

Whatever the means employed, suggestion plays a major rôle. It is a constant factor in motivation and in neutralizing strong emotional states. Suggestion, however, is effective only when a state of rapport exists between two individuals, and this state is consciously sought by the nurse. An attitude of understanding and acceptance is fundamental to such a

relationship. Such things as watching a patient too closely, oversolicitude and expressions of doubt that the patient will eat are all to be avoided because such procedures may create a negativistic attitude on the part of the patient. Use of fear, in the form of either force or threat, will destroy rapport and, hence, the effectiveness of any future suggestions given from a different angle of approach.

A patient with delusions of poisoning may be given reassurance by the nurse if she eats with the patient or tastes the patient's food. Persuasion, argument and contradiction are to be avoided because they only strengthen the delusion. It is better to ignore, to avoid or to reassure. Sometimes only special foods are thought to be poisoned and the issue can be avoided if such information is given to the dietitian.

Offer a Reasonable Time to Eat

When a patient refuses food, it is often better to leave him alone with it than to offer further positive suggestion in any form. However, when this is done, the food is sometimes thrown out of the window or secreted in the room. Before undertaking active assistance, the nurse may offer the patient a reasonable time in which to eat, with the warning that more insistent measures will be adopted if necessary. A time limit is often helpful when patients have a tendency to play around with their food.

Sometimes thiamin and insulin are prescribed as medications in an effort to stimulate appetite. A high caloric diet may be ordered with such medication but it is of no value, either psychologically or nutritionally, to increase the amount of food served to a patient until after he has started to eat. Large servings of food are often nauseating to a patient whose appetite is poor.

Spoon feeding is undertaken earlier with undernourished, easily fatigued patients than it is with those who are negativistic. Even after spoon feeding has been started, the nurse should be watchful of the first opportunity to withdraw this special attention to feeding.

When all normal methods of feeding have failed and the patient's nutritional status is threatened, the method of gavage is used. This is generally performed twice daily, but individual circumstances determine the frequency of feeding. For this reason, the feedings may be used occasionally as supplementary aids or they may be used continually as the only means of obtaining adequate nutrition for the patient.

To avoid the serious risk of misinterpretation, the purpose of the gavage feedings should be explained before they are started. The patient should be informed that gavage feedings are necessary for him because adequate nutrition cannot be obtained by more natural methods. The process should be presented as a treatment method that will be discontinued as soon as it is no longer needed. Every precaution must be taken to avoid giving the impression that the treatment is a means of punishment or persecution. The contents of the feedings should be explained to the patient in order to give him additional evidence of concern regarding his nutritional status.

Up to this point we have considered food intake that is deficient both in calories and in protective foods because the patients will eat little or nothing at all. In such cases the problem is primarily one of increasing the caloric intake. After the patient starts to eat, the protective foods will automatically become a part of his diet. On the other hand, we frequently have patients whose diet may be adequate in calories but lacking in a number of protective foods because of the many pronounced likes and dislikes of the patients or their firm belief that they cannot eat certain foods.

Catering to Alcoholics

Alcoholics are the most notable examples of patients with definite likes and dislikes. They like meats, highly seasoned sauces and spicy foods but will eat few vegetables and salads. This is no doubt a reflection of their dulled sense of taste and poor eating habits which have been built up during the years of drinking. Alcoholics are also inveterate drinkers of coffee. They make many demands to the nurse about food and coffee. The nurse informs the dietitian of as many of these requests as may seem advisable in each individual case, and all reasonable requests are granted.

When patients enter the hospital with the belief that they cannot eat certain foods, the physician in charge of the case requests the dietitian to visit these patients, get a list of the foods and serve the patients in accordance with their wishes, whether or not there is a physiological indication that these foods should be omitted from the diet. A patient's acceptance of hospitalization may depend at first upon obtaining such consideration regarding diet.

The dietitian may be able to increase the adequacy of the diet by putting some of the lacking protective foods into other foods that the patient is willing to eat. Foods that the patient refused upon admittance if sent up on the tray at a much later date will sometimes be eaten. Thus, by the addition of foods one by one over a period of weeks, the diet may become normal and adequate.

Reducing Excessive Intake

In contrast to patients who eat too little, we have those whose food intake is excessive. Such a patient eats everything served to him at mealtime, reorders often and does much nibbling between meals. He apparently has a continual desire to put something into his mouth. When this goes on until it becomes evident that there has been, or will be, an unhealthy gain in weight, the doctor may order a reduction diet for this patient. However, the advisability of such an order depends upon the individual case and the degree of rapport existing between the doctor and his patient. Until the diet is ordered, the dietitian continues to grant all the patient's requests for food, but she can succeed in decreasing the patient's caloric intake indirectly by making servings smaller.

A patient has the privilege of coming to the dining room when his physician gives an order to that effect. Such an order is given when a patient is well enough to be allowed group privileges and his behavior is acceptable to the group.

Thought is given to compatibility of interests in determining the seating arrangement for patients in the dining room, but men and women are not seated together at the same table.

We have waitress service but no printed menu. The waitress tells each patient what is on the menu for that particular meal, and the patient may order all or as much of it as he likes, adding any short orders he may wish. If the patient likes and often asks for certain special foods,

we try to keep these in stock to be served to him whenever he orders them.

This selective type of service gives the greatest amount of satisfaction possible under our hospital regime, as evidenced by the fact that often a tray patient who makes many complaints about the food will make few or no complaints after he starts to eat in the dining room. Moreover, such patients do not give short orders excessively. The very fact that they have the privilege of choosing is the solution to the problem. The change in emotional setting and the creation of more pleasant associations with food and eating give a psychic stimulation to the appetite which is also a factor in the situation.

Special diets are prescribed for their medicinal value or psychological value or both. When a physician wishes to put his patient on a special diet, he calls the dietitian and discusses the case with her. He may or may not ask her to visit the patient, depending upon the individual case and the method of handling it.

Before a patient is placed on a special diet, it is important that the physician tell the patient about it, especially if the dietitian has been asked to visit the patient. Some patients are hesitant about accepting a diet different from the others but an explanation from their physician aids acceptance. This is particularly true of paranoid patients, although it is questionable whether such patients should be on special diets.

Special diets are sometimes ordered for psychoneurotic cases. Such a diet order is given principally for its psychological value. There may be a case history of gastro-intestinal difficulties of long standing which upon examination are found to have no physical basis but which have been emotionally induced. From this extended experience of gastro-intestinal trouble, the patient may have become a diet crank and faddist. Such a patient wants to have a special diet prescribed for him, and yet such dieting may be harmful to him by acting as a constant suggestion that he is sick.

However, the patient will accept hospitalization and become oriented more readily if he is given, at least for the first few weeks, the diet that he has been following previous to admittance. The dietitian is always asked to visit such a patient. The opportunity to tell his dietetic troubles to her is always appreciated by the patient. Later, the dietitian may be able, indirectly or directly, through interest and suggestion, to add more foods to the diet.

An example of a diet prescribed for both its medicinal and psychological values would be an "anorexia diet." A patient placed on such a diet is usually a neurotic who is undernourished and completely uninterested in food. The dietitian is asked to visit the patient to indicate that she is interested in him and his welfare.

Incidentally, the dietitian tries to find out about a few dishes the patient likes especially well so that she can tempt his appetite with these. She can visit him again and find out more about his likes and dislikes later after he has started to eat a little and is more interested in food. Trays sent to such patients should be as attractive as possible as to both food arrangements and color, and the servings should be small.

Between-meal nourishments consist of fruit juices, milk drinks and fruit baskets which are sent to each floor in the morning and in the evening. The fruit and milk drinks are sent up to the floors in quart and pint bottles and are made up into individual servings there throughout the day. These liquid nourishments are given principally to the patients who need them, *i.e.* those who do not eat enough at mealtime.

At night, liquid nourishment or fruit is given to each patient in the hospital who desires it. Cookies for everyone are also sent up with the evening nourishments. In the winter months, a hot drink is often prepared in the kitchen by a nurse and sent up to the floors. This has a psychological value in helping to pass away some of the time on a long winter evening and in adding to the sociability of the group. If the patient is trying to gain weight and needs added nourishment between meals, a doctor's order specifying the food and the amount is necessary.

FOOD FOR THOUGHT

Helping the Meat Situation

To aid the dietitian who is perplexed over meat alternates and meat extenders the following printed material is recommended: "Meat for Thrifty Meals" — Farmer's Bulletin No. 1908, Superintendent of Documents, Washington, D. C., 10 cents. "Turkey As You Like It" and "Chicken the Great American Favorite"—Poultry and Egg National Board, 308 W. Washington Street, Chicago; "Nuts and How to Use Them" — Miscellaneous Publication No. 302, Superintendent of Documents, Washington, D. C., 5 cents; "Ways of Using Soybeans as Food"—Department of Home Economics, University of Illinois, College of Agriculture, Urbana, Ill.; "Meat Purchasing and Preparation"—American Dietetic Association, 185 North Wabash, Chicago, 10 cents; "Meat Alternates and Meat Extenders"—National Restaurant Association, 666 Lake Shore Drive, Chicago, 15 cents.

Training New Workers

On the subject of training new workers J. Marie Melgaard, director of the dietary department, University Hospitals, Oklahoma City, Okla., has this to say: "We have always given our new employes written sheets regarding the rules and policies of the hospital and detailed instruction sheets for their work. We keep cards on which each job is analyzed down to the last detail.

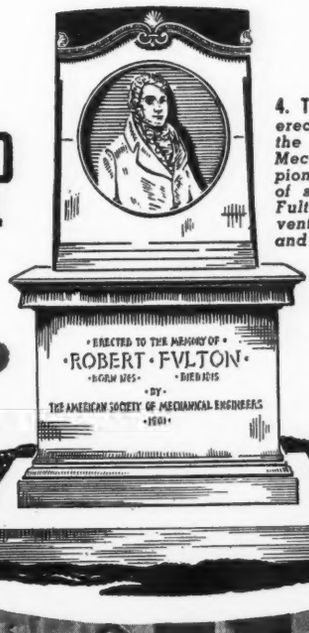
"Our group meeting with the employes is not scheduled regularly, except that we do have a cooks' meeting every morning. It is possible for us to do this because we have an unusually high type of white employe. How such a system would work out in hospitals situated around the industrial centers and in large northern cities where they employ either colored help or 'floaters,' I cannot say.

"All of these instructions, too, are of little avail unless they are followed up day after day with a relentless sort of patience."

We Must Save Fats

Because of the continued waste of fats the government is being required to dig into its reserves of glycerine at an alarming rate. More than a billion pounds of fats and greases go down the drains or into the garbage pails of American kitchens each year, according to the Office of War Information. Since fats are 10 per cent glycerine this would mean 100 million pounds of glycerine a year, or five times the amount needed to get out of the red.

SYMBOLS of LEADERSHIP



4. Tribute to ROBERT FULTON *erected in New York by the American Society of Mechanical Engineers. A pioneer in the development of steam-propelled ships, Fulton exemplifies the inventive genius of a free and liberty-loving people.*

Section of Main Kitchen, Massachusetts General Hospital, Boston

"VICTORY" COFFEE URNS NOW AVAILABLE

Illustration shows three-piece coffee urn battery, made of less-critical materials and available upon suitable priorities. Our complete line includes single urns and batteries in various sizes and types to suit your specific requirements . . . *Write for descriptive folder.*

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• When the steamboat "Clermont" first made her way up the Hudson in 1807, little did people dream of the sleek ocean greyhounds which were to ply the seas a century later. The progress of the American nation is marked by such outstanding examples of leadership in mechanical ingenuity. It is this same welding of knowledge, experience and imagination which has helped S. BLICKMAN, INC. attain a position of leadership in its own particular field. For more than fifty years Blickman-fabricated food service equipment has been noted for its cleanliness, durability and functional design. Today most of our facilities are engaged in the war effort. When victory comes, our full resources will again be available to serve your needs, whether it is a single unit or a complete installation designed for your specific requirements.

EST. 1889

Food Service Equipment for Hospitals in a New World

Announcing—

SPRING IS HERE

THERE is something about the fresh greens and yellows of spring that appeals to young and old alike. What comfort they hold for those who welcome them as harbingers of spring, bringing relief from ice and snow!

Spring enters the hospital, too, through the Easter trays dietitians set up—trays that are unlike any others because of some little decorative touch that gives them special appeal. It may be merely a small yellow cup containing nuts or candies, a place card that takes the form of a flower, or a colored egg—but it is something and that is what counts.

Because of the thousand and one problems that confront dietitians and every other hospital worker this year, plans must be kept simple. This has been considered in assembling the following suggestions for suitable Easter tray favors and instructions for making them.

Nut Cups—Plain and Fancy

Here are two types of nut cups that Sister Marie Lucille, Good Samaritan Hospital, Cincinnati, recommends. The first consists of soufflé cups covered with yellow crepe paper. Six petals are cut out and pasted on the bottom of the cup and allowed to curl up around it. The second cup, which is a bit fussier to make, has lavender construction paper as the base to which a soufflé cup covered with green crepe paper is pasted. Topping a piece of wire wound with lavender crepe paper is a bonnet made of white paper covered with the lavender paper. A lavender or yellow bow made of paper ribbon is fastened to the back of the bonnet.

If the desired effect can be accomplished by a place card, so much the better. Here is one that will attract favorable attention. Six inches of wire is wrapped with green crepe paper with two long, thin green paper leaves fastened to the base. About 2½ inches of wire is allowed to twine around to form a base, the remainder forming the stem. At the top is a yellow crepe paper flower—five petals with a fluted circular inside section. The green crepe paper should be carried far enough up on the wire stem to allow for fastening the flower.

What about an Easter egg vase? It sounds promising. Here is the way Sister Marie Lucille makes it. First, she colors an egg, removes the top of the shell and allows the contents to drain out. Next she places a test tube (small bacteriological size) inside, cuts one section from a cardboard egg case and pastes the eggshell securely inside. The cardboard egg holder may or may not be tinted. Real flowers can be placed in the vase.

Everyone enjoys bunny faces. Again, an eggshell does the trick. This time the yolk and the white are drained by pricking the end of the shell. On this are affixed two large lavender crepe paper ears and the face is drawn in ink. Whiskers may be made of hairbrush bristles. The bunny head is then ready for its cardboard base, following which it can be used as a place card or merely as decoration.

If any pill boxes are available they may be covered with varicolored crepe paper, treating the top and bottom separately, however, so that the lid can be tilted a little. A cellophane bow is fastened on top to which a flower or tiny cotton rabbit is pasted. The inside is filled with candy or nuts and a name card can be attached if desired.

It is not difficult to imagine an Easter bunny made of marshmallows. Marie L. Hines, director of dietetics, University Hospitals, Cleveland, uses one such candy for the head, another for the body and one each for the legs. The arms consist of one third of a marshmallow on a toothpick. The ears, cut from stiff pink paper, stand up jauntily and the face is sketched in red ink. A bow of pink crepe paper forms the final touch.

Lorene Kulas of Grandview Hospital, La Crosse, Wis., uses spools for her exceedingly attractive pots of flowers. In fact, she asks the seamstress to save them for her. If spools are not available, gumdrops will do. Pipe cleaners are then cut in the desired length, a gumdrop of the same color being assigned to each pot of flowers. This is then cut in flower petals, placed on the end of the pipe cleaner and put into the spool. Leaves cut from green crepe paper are added and a 6 inch paper doily is gathered up around the spool as on a pot of flowers and tied with colored ribbon. A card may be inserted reading, "Sincere Wishes for a Happy Easter." Miss Kulas finds gumdrops, paper doilies, pipe cleaners and a 10 cent package of assorted construction paper invaluable.

May Baskets Are Favorites

Speaking about flower pots, Edith L. Hoadley, dietitian, Salem Hospital, Salem, Mass., reminds us that when the dietitians made the tray favors (now they are made by the Ladies' Aid) one of the most popular was a May basket filled with real flowers, hepaticas usually.

"We took a paper drinking cup," Miss Hoadley explains, "and covered it with crepe paper in delicate tints, using our own originality in making an attractive basket. Sometimes it was put on in frills and sometimes in petal shape. The day before May Day my assistant went to her favorite childhood grove 20 miles from Salem and gathered the hepaticas. Then on May Day morning all of the dietitians were on duty at 5 o'clock filling the baskets. We usually purchased a flower like baby's breath from the florist to help fill in with the wild flowers. The paper cups were filled with water and the patient could keep this little basket on her bedside table for several days."

"The trays that bloom in the spring, tra la, have much to do with the case," sings the modern hospital dietitian. With apologies, of course, to Messrs. Gilbert and Sullivan.

• During this war you may get "only a taste" now and then of Dole Pineapple. The reason is good—¾ of the fruit and ⅓ of the juice we pack are going to the Armed Forces.

• Future crops of Dole Pineapple are being prepared for you. The fields we are putting in now, for example, will bear fruit in 1945.

HAWAIIAN PINEAPPLE PRODUCTS

DOLE

May Dinner Menus for the Small Hospital

Alice Falk, Dietitian, Silver Cross Hospital, Joliet, Ill.

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Beef Barley Soup	Hamburger Loaf, Mushroom Sauce	Escalloped Potatoes	Buttered Green Beans	Vitamin Salad	Fresh Rhubarb
2.	Julienne Soup	Fricassee of Chicken With Dumplings	Mashed Potatoes	Buttered New Peas	Tomato and Watercress Salad	Strawberry Ripple Ice Cream
3.	Cream of Celery Soup	Roast Lamb	Parsley Buttered Potatoes	Harvard Beets	Stuffed Prune Salad With Cream Cheese	Chocolate Pudding
4.	Beef Broth	Noodles Neapolitan		Buttered Spinach	Celery and Olive Salad	Peach Cobbler
5.	Tomato Bouillon	Swiss Steak	Steamed Potatoes	Succotash	Head Lettuce, Thousand Island Dressing	Baked Cinnamon Apple
6.	Consommé	Broiled Calf's Liver	Creamed Potatoes	Buttered Carrots and Peas	Spring Salad	Whipped Gelatin, Chopped Nuts
7.	Vegetable Juice Cocktail	Fried Filet of Pike With Lemon	Mashed Potatoes	Escalloped Tomatoes	Asparagus, Beet, Deviled Egg Salad	Pineapple Sherbet
8.	Cream of Pea Soup	Lamb Patties	Spanish Rice	Buttered Beets	Salad Greens, French Dressing	Gingerbread With Hard Sauce
9.	Chicken Broth With Rice	Baked Ham	Candied Sweet Potatoes	Buttered Cauliflower	Tinted Spiced Pear and Olive Salad	Chocolate Ice Cream
10.	Cream of Mushroom Soup	Fricassee of Veal	Homemade Noodles	Buttered Wax Beans	Hearts of Lettuce, Russian Dressing	Fresh Fruit Cup
11.	Vegetable Soup	Eggs à la King	Baked Potatoes	Buttered Broccoli	Vegetable Salad	Lemon Pudding
12.	Cream of Asparagus	Roast Ribs of Beef	Browned Potatoes	Buttered Carrots	Hawaiian Salad	Pineapple-Apricot Cake
13.	Beef Soup With A. B. C. Noodles	Ham Croquettes, Cream Gravy	Mashed Potatoes	Corn Soufflé	Chef's Salad	Almond Cornstarch Pudding
14.	Chilled Tomato Juice	Baked Halibut	Creamed Potatoes	Buttered Asparagus	Cabbage Salad	Orange Sherbet

May Dinner Menus for the Small Hospital

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
15.	Consommé	Beef Stew	Buttered Rice	Fresh Spinach	Spiced Apricot Salad	Tapioca Cream
16.	Fruit Cup	Roast Veal	Mashed Potatoes	Buttered Carrot Chips	Perfection Salad	Butterscotch Sundae
17.	Cream of Vegetable Soup	Broiled Lamb Chops	Baked Potatoes	Buttered Peas	Apple, Celery and Raisin Salad	Spice Cake
18.	Vegetable Juice Cocktail	Baked Spaghetti With Tomato Cheese Sauce	Buttered Shoestring Beets	Buttered Green Beans	Egg Salad	Fruit Gelatin
19.	Split Green Pea Soup	Broiled Steak	Browned Potatoes	Mashed Rutabagas	Fresh Vegetable Salad	Cottage Pudding With Lemon Sauce
20.	Cream of Corn Soup	Liver Patties	Escalloped Potatoes	Stewed Tomatoes	Stuffed Celery	Cherry Cobbler
21.	Bouillon With Rice	Filet of Sole, Tartare Sauce	Diced Creamed Potatoes	Buttered Spinach	Grapefruit and Orange Salad	Raspberry Ice
22.	Lima Bean Soup	Meat and Vegetable Pie	Parsley Buttered Potatoes	Buttered Celery	Half-Peach Salad	Macaroon Custard
23.	Vegetable Soup	Roast Chicken	Mashed Potatoes	Fresh Asparagus	Tomato and Endive	Pineapple Ice Cream
24.	Fruit Juice Cocktail	Liver Loaf, Spanish Sauce	Creamed Potatoes	Buttered Green Lima Beans	Avocado and Romaine Salad	Prune Gelatin
25.	Tomato Soup	Vegetable Chop Suey	Rice	Buttered Broccoli	Radish, Cucumber, Celery Salad	Date Pudding
26.	Chicken Gumbo Soup	Braised Beef	Whipped Potatoes	Harvard Beets	Fruit Salad	Angel Food
27.	Vermicelli Soup	Breaded Veal Cutlets	Cottage Potatoes	Creamed Green Beans	Stuffed Tomato Salad	Fresh Strawberries
28.	Vegetable Soup	Finnan Haddie	Parsley Potatoes	Buttered Spinach	Coleslaw	Orange Sherbet
29.	Tomato Bouillon	Lamb Stew	Buttered Noodles	Buttered Asparagus	Assorted Relishes	Fruited Spanish Cream
30.	Cream of Mushroom	Stewed Chicken	Mashed Potatoes	Buttered Fresh Peas	Pineapple-Nut Salad	Strawberry Shortcake
31.	Julienne Soup	Salisbury Steak	Steamed Potatoes	Mixed Vegetables	Head Lettuce Salad	Baked Apple

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago.

Here's how Swift's "Guest-Quality" Allsweet Margarine assures the nutrition needed in a spread

FOOD ENERGY
3,300 calories per pound

VITAMIN A
9,000 U.S.P. units per pound

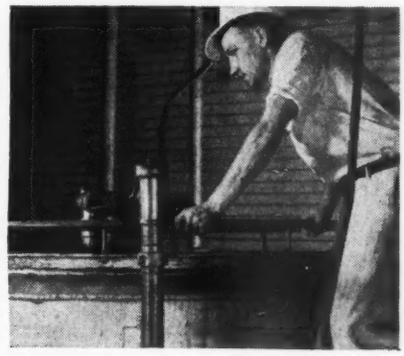
DIGESTIBILITY
95 to 97%

Guaranteed by Good Housekeeping — Accepted American Medical Association

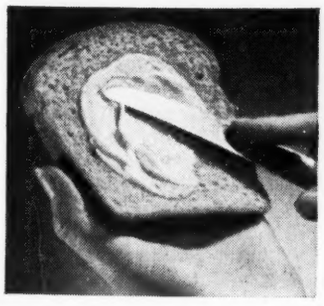
APPROVAL! In wartime or peace—the flavor and nutritive value and consistency and cooking quality of modern Allsweet are far superior to the oleomargarine of several years ago. Extensive research in Swift's great food laboratories, plus modern, carefully controlled production methods, result in an all-round fine money-saving spread. A spread which wins the Seal of Acceptance of the American Medical Association's Council on Foods, as well as the Good Housekeeping Bureau's Seal. Recommend it with confidence, use it and enjoy it.

RICH, WHOLESOME INGREDIENTS. From America's own farms come the energy-giving ingredients that go into Allsweet. Pure bland oils, and pasteurized skimmed milk—for the extra energy that wartime demands of the home front. Allsweet provides 3,300 calories per pound.

VITAMIN A IS ADDED. Pure concentrate of Vitamin A is added to Allsweet, assuring a minimum of 9,000 U.S.P. units in every pound. The average daily consumption of Allsweet (2 oz.), so fortified, furnishes 28% of the minimum daily requirement of Vitamin A for the adult.



CONTROLLED SANITATION. Strict laboratory control in every step of processing assures the highest degree of sanitation. Allsweet production is the result of years of Swift research in the world's largest commercial food laboratories. You can depend on Allsweet as a *wholesome* spread.



WIDE RANGE OF SPREADABILITY. Table spreads are taken from the cold refrigerator to the warm kitchen with temperature changes from about 48° to 90°. Yet Allsweet does not chip as it comes from the refrigerator, nor quickly get soft in hot weather.

COOKING QUALITIES—EXCELLENT! There's no danger or nuisance from spattering when Allsweet is used in the frying skillet. And for baking, Allsweet is a fine shortening that adds *milk-flavor richness*. It mixes easily, has excellent creaming qualities.

The Result of Remodeling

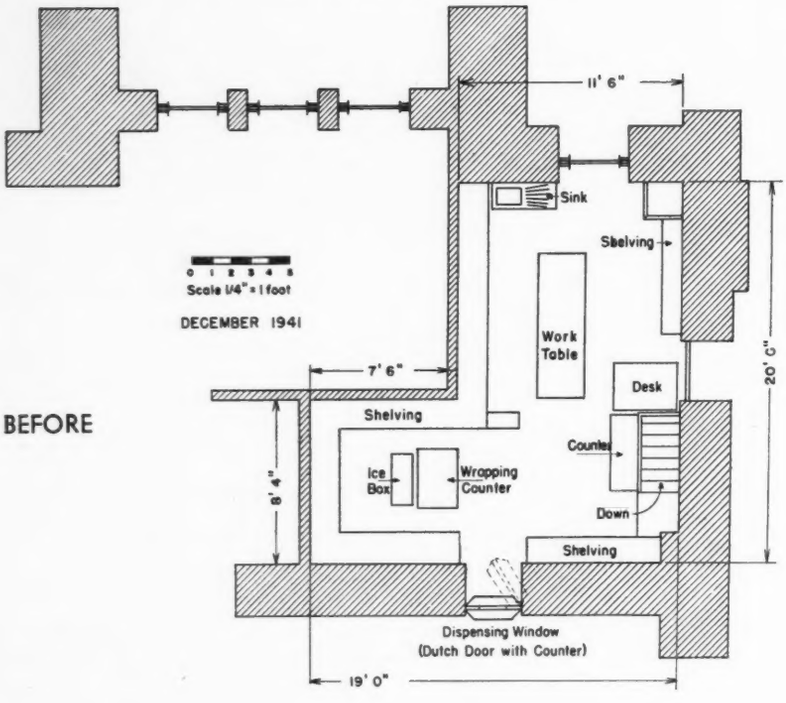
A "Before and After" Story

ANTHONY J. J. ROURKE, M.D.
and ROBERT F. BROWN, M.D.

PHYSICIAN SUPERINTENDENT
AND ASSISTANT TO THE SUPERINTENDENT
STANFORD UNIVERSITY HOSPITALS
SAN FRANCISCO

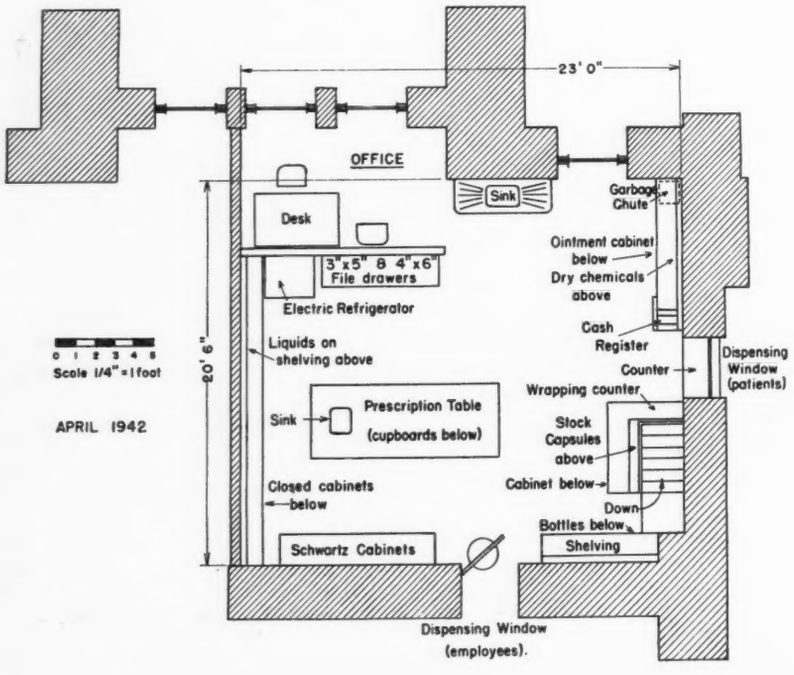
PHARMACY BEFORE ALTERATION

BEFORE



AFTER

STANFORD UNIVERSITY HOSPITAL
REMODELED PHARMACY



THE pharmacy of Stanford University Hospitals has been in its present location in the out-patient department since 1890. At that time this building was the Cooper Medical College. In 1894 Lane Hospital with a capacity of 180 beds was built and given to Cooper Medical College by Doctor Lane. When this hospital was built it had an independent drug room. However, after a few years this was closed and thereafter all pharmaceuticals were prepared in the pharmacy in the Cooper Medical College building. In 1908 the Cooper Medical College was deeded to Stanford University and in 1917 the Stanford Hospital with 130 beds was constructed.

Since 1890, when only a small number of out-patients were treated in the clinic of Cooper College, the prescription work of the pharmacy has increased tremendously. In 1941, 50,550 prescriptions for 138,532 out-patient visits and 56,500 hospital orders for 100,061 in-patient bed days were filled.

During the fifty years between 1890 and 1941 the only additional floor space acquired by the pharmacy was provided by building a stairway to the basement below. Gradually, from year to year shelf space was obtained by building shelves over all available wall space. Early in 1942 the remodeling of the department was begun and the work was completed in April of that year.

The prescription table was made 10 feet long, 44 inches wide and 39 inches high, with a stainless steel top, closed cabinets below, a built-in black acid-resisting sink and gas and electric outlets. The counter height provides working comfort for the

The routine use of Prostigmin Methylsulfate 'Roche,' 1:4000 provides a convenient and effective means of preventing postoperative abdominal distention and urinary retention. Since many hospital staffs have been drastically reduced, every precaution which can be taken to obviate troublesome postoperative procedures is of major importance. Any measure that affords smoother convalescence for the patient and reduces the work of the staff, is a doubly valuable expedient. To minimize discomfort due to abdominal or bladder atony inject 1 cc of Prostigmin (1:4000 solution) intramuscularly immediately after operation. Follow with 5 similar 1-cc injections at 2-hour intervals. Additional injections may be given if necessary. HOFFMANN - LA ROCHE, INC. • ROCHE PARK • NUTLEY • NEW JERSEY.

PROSTIGMIN *'Roche'*

pharmacist and the stainless steel top facilitates cleaning. A 4 inch inset was made around the bottom of this table and all other cabinets for toe space.

The prescription liquids were put into 16 and 32 ounce square French bottles. Shelves for these were built 6 inches deep, high enough for a 2 inch clearance and with stripping behind the bottles so that they line up easily when placed on the shelves. The top shelves in the remodeled pharmacy are built at a height of 79 inches from the floor, which can be reached without standing on a stool. The counter on which these shelves stand is 16 inches deep and 39 inches from the floor. Cabinets below with sliding doors provide additional shelf space.

Four sections of standard sectional filing equipment provide the equivalent of 160 linear feet of shelf space in which many of the proprietaries are kept. These dustproof storage cabinets hold the less used drugs. One section consisting of four drawers is provided with a lock and this is used for narcotics. This section is unlocked only when narcotics are being dispensed.

The Dutch door at the entry was replaced by a door with a cut-out window through which doctors, nurses and employes are served. A counter for serving out-patients was built into the doorway that had been permanently closed in the old pharmacy.

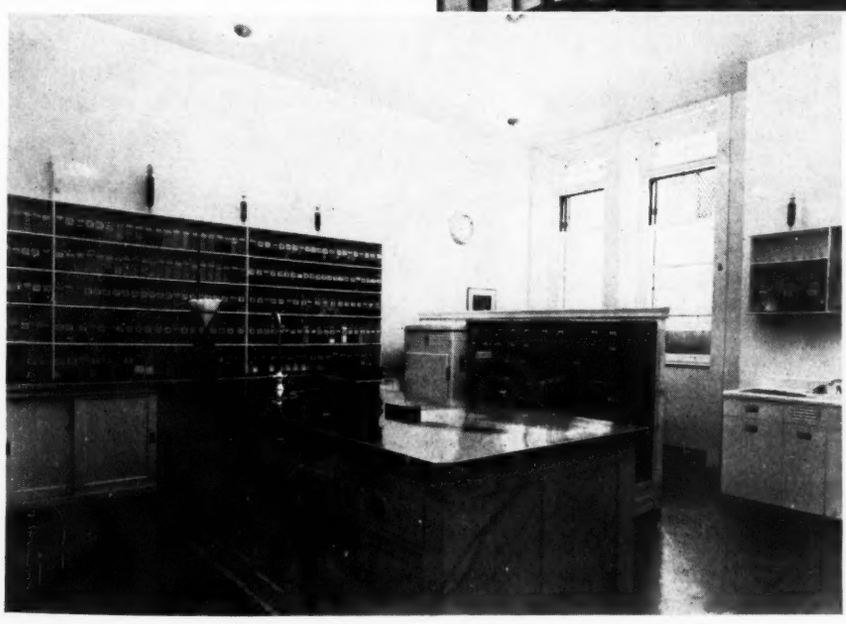
Between the prescription counter and the door and around the stairwell a wrapping counter was constructed. A string container and paper dispenser for 6, 9 and 12 inch paper are placed on this counter near the window serving the out-patients.

The pharmacist who is stationed before the window has the wrapping counter on his right, the cash register facing him on the left and a pick-up French type of telephone above the cash register. He receives prescriptions and gives them to a pharmacist working at the prescription table who fills and labels the prescription. As they are handed back to him he checks them and numbers in duplicate the prescription and the prescription order with a consecutive numbering stamp that is kept on the counter. The prescriptions are entered in order in prescription files once every day.

Standard round bottles with wide mouths are provided for the dry chemicals and are stored upon shelves of the type previously described. In the cabinet below the wrapping counter ointments are kept in enameled canisters. They are found to be cleaner and to have a better appearance than glass ointment jars. Preparation of some ointments is done on a glass plate on the counter. A garbage chute with a drop snap door in the end of this cabinet empties into a 40 gallon refuse can in the basement.

An acid-resisting cabinet sink with shelving and drawers was placed against the wall and between the windows. Six 4000 cc. aspirator bottles with glass spigots for dispensing stock liquids and a 5 gallon syphon bottle for distilled water were placed on shelves above the sink.

The sink cabinet provides adequate space for storage of mortars, pestles, mixing pans and bowls and drawer space for spatulas, knives and stirring rods. This sink is free for washing dishes and filling large containers because water is also available on the prescription table from the smaller sink there.



Above: It took fifty years for the pharmacy to get to looking like this and (left) only three months to make it look like this.

A 5 foot partition encloses a semi-private office which cannot be viewed either from the prescription window or from the main floor of the pharmacy. By standing up at the desk the pharmacist can see over all of the pharmacy and this provides super-

A reasonable amount of peace and privacy is afforded the pharmacist by a 5 foot partition that encloses his office.

vision at all times. Here the pharmacist can make purchases from the drug salesmen or carry on discussions of new products in comparative quiet.

Against the outer wall space of this partition were placed an electric refrigerator and 79 reclaimed drawers. Formerly, the several hundred dollar inventory of biologicals (serums, antitoxins, vaccines, insulin and liver extract) was kept in an icebox, the temperature of which was neither constant nor sufficiently low. The relative cost of a 6.3 cubic foot electric refrigerator is small compared with the large inventory when the deterioration of the biologicals is prevented.

The file drawers are reclaimed tiers of 3 by 5 inch and 4 by 6 inch card files which have been converted into ampule cabinets. Ampules are filed alphabetically in these. This arrangement enables a night supervisor to find any ampule quickly when the need arises.

Three pharmacists and two messengers worked in the pharmacy before its alteration; they could not pass each other in many parts of the room. One executive pharmacist, three assistant pharmacists and two messengers are now employed. They move around in the room easily and this, together with the two dispensing windows, has increased efficiency. When two men pharmacists left because of the war two women were employed to replace them.

The pharmacy is kept open from 8 a.m. until 8 p.m. six days a week and three hours on Sunday morning. During the week the executive pharmacist, two of his assistants and one messenger come to work at 8 a.m. The messenger makes rounds through the hospital immediately, gathering orders for patients and stock bottles for refilling from the wards and private floors.

As soon as he returns, all of these orders and prescriptions are filled before the pharmacy windows are opened. The messenger makes hourly delivery rounds through the hospital and on these rounds picks up other hospital orders. A successful effort was made to decrease the number of local telephone orders by asking that all hospital orders be made on written requisitions and given to this delivery boy on his rounds.

At 11 a.m. the third assistant pharmacist arrives. She relieves the others during lunch hours and works until 8 p.m. The second messenger arrives at 3 p.m. and takes over the hospital delivery while the other messenger dusts one section of bottles and refills the stock bottles therein. From 5 until 8 p.m. the pharmacy fills many prescriptions which, before the hours were extended, were sent to outside neighborhood pharmacies. Two of the employes, including at least one pharmacist, work three hours every third Sunday.

In the maintenance of the pharmacy three points are stressed: (1) returning all stock bottles to shelves after using, (2) keeping bottles and wastepaper off the floor and (3) cleaning the pharmacy every night.

The basement of the pharmacy is still to be remodeled. At present it is filled with shelves for the storage of commodities to replace stock upstairs. It is to be divided into two rooms, one for manufacturing and one for storage. The manufacturing room will contain: a large work table; a large sink; a water still (distilled water is now brought from the hospital surgery which is a long distance from the pharmacy); a sirup percolator, and a colloid mill.

When this is completed all shipments will be received downstairs through a chute, since this basement is below street level. Here they will be placed on an inventory kept in a card index. As materials are taken upstairs they will be removed from this inventory. When this is completed an inventory of the whole pharmacy can be taken by adding the basement inventory, which is current, and taking an inventory of the dispensing pharmacy upstairs.

The walls of the pharmacy were finished with gloss white enamel and the ceiling with flat white paint. The three outside windows and four 500 watt incandescent ceiling fixtures provide excellent light. The floor of 8 inch square asphalt tile blocks is a marbleized brown and white pattern. The brown color is picked up by the solid brown of the linoleum which covers all of the counters.

The supplies for this remodeling were purchased before the war began, so that no shortage of material was encountered. The labor was provided by the maintenance department of the hospital.

The pharmacy remained in operation during all of the remodeling because no other space was available. The cabinet work was done in the carpenter shop and each piece of equipment was brought in after one coat of paint had been applied; the electric installations were made on week ends, and the painting was done at night.

After this was completed the floor was covered with ⅜ inch plywood and the asphalt title was laid over it. Working only during afternoons on sunny days, the job was completed in three months.

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NOTES AND ABSTRACTS

**Conducted by the Staff of the Pharmacology Department
Wayne University, Detroit**

Fatigue

The term fatigue is often employed to describe a sensation of psychic state rather than an objective phenomenon. There are so many physical and psychologic factors involved that a simple direct statement defining the condition would hardly suffice. From the physiologic viewpoint it has been defined as a disturbance of the normal physiologic processes with the production of the chemical products of fatigue. This involves a number of reactions of the individual to his environment which may be physical-objective and psychologic-subjective in nature. The physical manifestations of fatigue are a lowered capacity for doing work and a reduced output while on the task.

Physical fatigue can be grouped into several different states. It may be temporary, subacute, chronic, local or general. In the temporary state the awareness of a feeling of tiredness is present in addition to a transitory diminution in working power from which recovery takes place after a short period of rest. The previous history of the individual has some bearing on the degree and extent of temporary fatigue. A beginner may show manifestations quite early but, as he becomes skilled in the task, the time required to produce temporary fatigue becomes progressively longer. The subacute stage of fatigue is reached when continued activity creates an abnormal demand on energy. A depletion of energy reserves occurs, as well as an ineffective removal of the products of fatigue.

If this condition is allowed to continue, the chronic state supervenes. Signs of overwork in its initial stages develop and may ultimately lead to incapacitating illness. This is different from exhaustion, an extreme condition in which the performance of work is impossible.

Local fatigue affects isolated muscle groups that have been most actively used. General fatigue affects the body as a whole and may arise from physical, mental or emotional sources. Muscular and mental effort, although local in the beginning, can become general if sustained long enough. Under hard muscular activity the peripheral physiologic functions of metabolism, respiration and circulation bear the brunt of fatigue. In less strenuous activities, the so-called white-collar jobs, the central nervous system is almost exclusively the origin of fatigue.

Mechanism of Energy Production

Fatigue is the result of the expenditure of energy. The search for the substances that act as a source of energy for muscular contraction has been beset with difficulties because the chemical components in muscle responsibilities exist for only a brief period of time during an active contraction. Substantial agreement exists that the energy is apparently derived from three substances, namely, glycogen, phosphocreatinine and adenyl-pyrophosphate. The actual energizing of the contractile process seems to originate from the hydrolysis of adenyl-pyrophosphate. Since this is an exothermic reaction that liberates considerable amounts of energy with explosive rapidity and is found early during muscle contraction, there is existing support for this concept.

The second chemical process appearing during a muscle contraction is apparently the breakdown of phosphocreatinine. This is likewise an exothermic reaction and furnishes the energy

for resynthesis of adenyl-pyrophosphate. Because lactic acid does not make its appearance in muscle until some time after a contraction is well under way it is believed that glycogen, the source of lactic acid, plays an indirect rôle; it serves solely for restitution processes. The fatigue following hypo-insulinism of diabetes, which leaves glycogen unavailable to body economy, has some bearing on this point.

This rather complicated means of energy production is fundamentally sound. For instance, if energy was produced by an aerobic process in the active muscle, violent exertions probably would not be possible. The immediate demands for additional fuel could not be met owing to the lag in circulatory and respiratory adjustments. The regulating mechanism that prevents muscular overexertion to the point of complete exhaustion and injury would be lost in that the excessive accumulation of lactic acid is a limiting factor and depresses or inhibits the power of contraction. Also, the capacity that the body has for accumulating an oxygen debt would not exist if the energizing processes were not anaerobic in character.

Pharmacologic Aspects of Fatigue

The exhaustion of the organic phosphate constituents and the concomitant excessive accumulation of lactic acid in muscle result in temporary muscle paralysis. However, the site of the fatigue in an intact animal is not the muscle or the nerve but rather at the functional entity, the neuromyal junction. A chemical mediator of muscle contraction, acetylcholine, is liberated at the nerve ending that bridges the gap between the nerve and the muscle fiber it innervates. An enzyme, cholinesterase, rapidly destroys acetylcholine when it completes its function. Two conditions in which this peripheral mechanism fails to function properly are myasthenia gravis and myotonia. In the former the weakness and fatigability of the muscles are apparently due to a defective liberation of acetylcholine or an overproduction of cholinesterase. Physostigmine or, better, prostigmin, which prevents the enzyme from acting on the mediator, produces decided improvement. The latter condition represents an overlong action of acetylcholine manifested by marked muscular tonus rather than by a weakness. Drugs with a curarizing action, more specifically derivatives of quinine, depress the cholinergic nerve endings and help to relieve the abnormally prolonged stimulus.

Acetylcholine is also produced by the craniosacral (parasympathetic) autonomic nerve endings. Other nervous influences upon the adrenals release epinephrine-like substances that activate the sympathetic system. Both of these powerful agents control the automatic organs of the body, the regulatory mechanism for integrating the action of these substances lying in the hypothalamus. Ordinarily the cerebral cortex polices the functions of the hypothalamic nuclei but in generalized fatigue this control may be lost. The resultant erratic behavior of the hypothalamus can stimulate the autonomic nervous system causing the excessive production of acetylcholine and epinephrine-like substances. The constitutional symptoms complained of are of greater scope than those of ordinary fatigue. They may run the gamut of muscular weakness and distortions of bodily functions to psychic instability. Rest and reassurance seem to be the best therapeutic procedures.

Fatigue associated with gonadal decline may be extremely marked in both its mental and physical manifestations. The administration of the male sex hormone in men produces rapid amelioration of symptoms. The muscular weakness disappears and psychic difficulties improve as ability for mental work is regained.

A deficiency in certain of the vitamins can produce fatigue as an early symptom. Because of the fundamental rôle of B_1

or thiamine in carbohydrate metabolism, deficient intake of this substance will lead to severe physiologic derangements. Among these is a loss of muscular strength that may even progress to complete paralysis. The response to thiamine therapy is often dramatic.

Fatigue and Disease

Fatigue as a cause of disease, especially vague chronic disturbances in health, has frequently been considered as an underlying factor although there is no medical evidence that prolonged fatiguing periods of effort adversely affect the health of the individual.

Tremendous expenditures of nervous energy can result from vigorous mental effort and prolonged emotional and psychic strains. Prescribed rest will enable the body to rebuild its depleted vital energy reserves and may compensate for any derangement in physiologic functions that might exist. Recent studies by McKenzie bring out the fact that abnormal demands of environment, such as noise and swing shift, may favor susceptibility to disease, but methods have been developed to prevent such fatiguing situations as may lead to a disastrous illness.—ARNOLD J. LEHMAN, M.D.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Civilians in War Time

In the experience of Denny-Brown (reported in the *Journal of Laboratory and Clinical Medicine,* February 1943, under the title, "Effects of Modern Warfare on Civilian Populations"), the prevention of the various types of civilian casualties resulting from air bombing is more important than the treatment of the casualties, once these have occurred.

First, as many people as possible should be evacuated from the city that is under constant bombardment. Even those engaged in essential work should leave for forty-eight hours.

Second, the ordinary person should be encouraged to take shelter during a bombardment in basements under or near his own home or near his place of work rather than in the public shelters, which, no matter how large, cannot be made large enough to accommodate the population of a modern city. While many people thus take shelter, about one third of the population is engaged in air raid defense work. This number includes those in hospital service. In this group, those who must differentiate between patients in true shock and those with hysteria or other nervous disorders have the greatest responsibility.

Hysterical patients can readily be treated with hot coffee, sedative and overnight rest. The remainder, however, include those with deep emotional depressions.

It is the author's impression that the scale of persistent disability is little more than the rate of peace-time nervous illness, and it is the person with a positive family or personal history of psychoneurosis who is most likely to break under the strain.—SIGMUND L. FRIEDMAN, M.D.

Recommending Electrocardiography

An increase in electrocardiographic studies of from 15.5 to 38.9 per cent per hundred patients admitted to the medical wards or the medical clinics during 1929-1940 is reported by Arthur T. Grieger, Massimo Calabresi and Loren F. Blaney in their article, "A Jusification for the Increasing Use of Electrocardiography in Hospital Practice," *American Journal of Medical Science,* February 1942.

In view of the steadily increasing demand for this laboratory service, these doctors inquired specifically as to whether the additional information justified the increased cost of performing this work.

The research concerned the following aspects of the problem: (1) the relation between the increasing use of electro-

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cardiography and the proportion of normal and abnormal records obtained; (2) an estimate of the clinical value of representative groups of electrocardiograms during a year of small demand as compared with a year of large demand, and (3) the clinical value af routine electrocardiography.

Results of the study have shown:

1. That as more electrocardiograms were obtained the proportion of abnormal tracings paralleled the increase in the total number of records for each year, while the figures representing normal records showed a more gradual ascent.

2. With the increase in the number of electrocardiograms obtained in patients in this group a larger proportion of tracings was of decisive and exceptional significance.

3. Routine electrocardiograms were made of a group of patients for whom these studies were not requested by the attending staff. The patients whose charts pointed to cardiovascular disease were placed in a separate group so that the group analyzed consisted of patients who were clinically definitely free of cardiovascular disease. Of this group 12.2 per cent showed abnormal electrocardiograms. Excluding from this group the tracings that showed low voltage and were considered abnormal because of this finding, there still remained 7.8 per cent that were definitely abnormal. These abnormal tracings were obtained in increasing ratio to the age, except for those over 60.

The authors comment that this fair proportion of patients who showed abnormal electrocardiograms in the absence of any clinical findings suggesting heart disease pointed to the possibility that the patient may have suffered an acute infection that left residual damage in the heart and resulted in an abnormal electrocardiogram, but these patients may not have clinical heart disease and may be considered normal from the functional aspect.

The authors conclude by recommending electrocardiography as a desirable laboratory test for those with diseases that are known or suspected to involve the heart secondarily, in elderly patients as well as in cardiac cases.—Abraham Jezer, M.D.

Abdominal Wounds

Modern methods in anesthesia have aided materially in reducing the heretofore extremely high mortality among those shocked patients with abdominal wounds who reach the operating table. Despite this, however, there are important differences of opinion among surgeons, according to a *Lancet* editorial, "Anaesthesia for the Belly-Wound," for Sept. 5, 1942.

For example, American surgeons regard spinal anesthesia as the most suitable for this type of case but the British surgeons will not countenance its use. Gordon-Taylor nas even gone so far as to say "Spinal anesthesia spells euthanasia for the shocked abdomen." The British regard this method as dangerous because it dilates the small blood vessels which, though unimportant normally, become vitally important during shock. As might, therefore, be anticipated, the best results have been obtained by the use of local infiltrating anesthesia, sometimes combined with splanchnic block. This is frequently supplemented by a general anesthesia used for narcosis, not for relaxation.

The general anesthetic will vary with the battle zone: in the city, cyclopropane, with which oxygen percentages of from 75 to 90 per cent can be given, is widely preferred; on the battlefield ether has been found to have the greatest margin of safety when used only as a complementary anesthetic. Intravenous barbiturates also have much in their favor and are readily given by injecting one of these into the rubber tube delivering a blood transfusion.

Local anesthesia may possibly have one important disadvantage, *i.e.* procaine, *in vitro,* is a potent inhibitor of sulfonamide activity.—Sigmund L. Friedman, M.D.

NEWS IN REVIEW

Bill for Emergency Maternity Care for Wives of Enlisted Men Passed by Senate

WASHINGTON, D. C.—An appropriation for emergency maternity and infant care for the wives and children of enlisted men and noncommissioned officers in the armed services was passed by the Senate on March 12 as an amendment to the $4,000,000,000 deficiency appropriation bill.

The amount of $1,200,000 for allotment to states by the Children's Bureau for the fiscal year of 1943 is sought. The funds are to be administered by state health agencies.

The maternity care program was first put into effect in August 1941 when the Washington State Health Department initiated it in the Fort Lewis area. By Oct. 1, 1942, federal funds had been requested to provide obstetric and pediatric medical and hospital care for the families of men in military service.

Twenty-seven states and the District of Columbia are carrying out the program at the present time on funds allotted to meet their immediate needs. Bills to authorize such appropriations were introduced as early as last August.

Only ward care on a per diem basis is purchased by the state health agencies and only in approved hospitals or those inspected and approved by state health agencies. Governmental hospitals are used whenever possible. In the state of Washington, physicians are paid on a case basis. In several states hospitalization and medical care services are on a state-wide basis; others have limited the program to critical areas.

Twenty-Two Firms Given Army-Navy Production Award

Eighteen firms in the health supply field joined the ranks of manufacturers who have received the Army-Navy "E" between February 15 and March 15:

Merck and Co., Inc., East Falls Plant, Philadelphia, and Stonewall Plant at Elkton, Va.; Campbell Soup Company, Central Division, Chicago; Lederle Laboratories, Incorporated, Pearl River, N. Y.; Machlett Laboratories, Incorporated, Springdale, Conn.; Motor Products Corporation, Detroit; Stokely Brothers and Company, Incorporated, Stokely-Van Camp, Indianapolis; Baxter Laboratories, Inc., Glenview, Ill.; Anacin Manufacturing Company, Knoxville, Tenn.; Electric Vacuum Cleaner Company, Incorporated, East Cleveland, Ohio; Hendrick Manufacturing Company, Waterloo, Iowa; Ingram-Richardson Manufacturing Company, Beaver Falls Plant, Beaver Falls, Pa.; Johns-Manville Corporation, Borough of Manville, N. J.; National Electric Instrument Company, Incorporated, Elmhurst, N. Y.; Republic Steel Corporation, Steel and Tubes Division, Cleveland; Seamless Rubber Company, New Haven, Conn.; Edison General Electric Appliance Company, Incorporated, Chicago; Patterson Screen Company, Towanda, Pa., and General Electric Company, Bridgeport, Conn.

Awards were also made on March 22 to: Armour Laboratories, Chicago; American Laundry Machinery Company, Cincinnati; Hynson, Westcott and Dunning, Inc., Baltimore, and Kelley-Koett Mfg. Co., Covington, Ky.

Fans and Blowers Now Under Limitation Order L-280

WASHINGTON, D. C.—Control of production and delivery of fans and blowers were placed under a new limitation order February 17. Order L-280 affects all types of new devices or machines that move, compress or exhaust air by centrifugal, rotary or axial means, with certain definite exceptions specified.

An "approved order" must bear a preference rating of AA-5 or higher or one approved by the Director General for Operations. The control provision of L-280 does not apply to purchase orders for repair parts, within certain value limitations, or to meet emergency breakdown situations specified in the order.

A manufacturer who cannot fill a purchase order within a required delivery date must return it to the purchaser within twenty days.

Floor Machine Order Amended

WASHINGTON, D. C.—Although restrictions were recently imposed on the manufacture of floor finishing and floor maintenance machines and industrial vacuum cleaners by amending Order L-222 on March 2, the W.P.B. has authorized the continued production of these items to take care of special situations and to meet requirements of the armed forces and defense industries. Production and fabrication of floor maintenance machinery is scheduled to stop completely unless specifically authorized. Fabrication of parts for industrial vacuum cleaners without authorization is also prohibited.

Children's Bureau to Pay Ward Cost Rates to Voluntary Hospitals

WASHINGTON, D. C.—Another important federal agency has been added to the group that has agreed to compensate voluntary hospitals on a per diem basis.

The U. S. Children's Bureau announced on March 6 that it has recommended such a system to state agencies administering maternal and child health and crippled children's programs under the Social Security Act for the fiscal year beginning July 1.

Specifically, the bureau recommends that hospital care under these programs be purchased at the per diem ward cost rate for each hospital for the first two weeks of hospital care and at 75 per cent of this rate thereafter, except in states in which the hospital rate to be paid by public agencies is established by law. The bureau will not approve rates in excess of per diem ward cost.

For the fiscal year 1944, each hospital is asked to submit certified copies of its most recent statement of annual operating costs and its per diem ward cost calculated in accordance with the methods recommended by the bureau last July.

The rate will include all in-patient operating costs but will exclude outpatient costs and nonhospital expenses, such as educational, religious, gift-shop and lunch counter. Certification of the statement by an independent public accountant is required.

The classification of operating expenses follows in general that recommended by the American Hospital Association. Approximately 1000 hospitals are affected.

"Specialists in hospital administration," states a release from the bureau, "are in general agreement that the statement by the Children's Bureau is an important forward step that should result in more equitable reimbursement to hospitals and in vastly improved accounting records."

Of the total of more than $16,000,000 of federal and state funds expended annually for these programs, between $4,000,000 and $5,000,000 is for hospital and convalescent care of mothers and children.

The policies were unanimously approved for the hospital field by Dr. Robin C. Buerki, Dr. Basil C. MacLean, C. Rufus Rorem and Henry G. Hooper.

Service Pins for Blue Cross

The Hospital Service Plan Commission has been advised by the special committee that designed the war service emblem for hospital employes that it would be proper for Blue Cross Plan employes to wear the service pins. Accordingly, several plan directors have ordered a small supply for their employes.

N.R.P.B., Social Security Proposals for Health Care

(*Continued from page* 49)

proposals are included in the section recommended for postwar rather than immediate action is taken by hospital students to mean that the board and the President do not expect legislation at present.

Furthermore, N.R.P.B., unlike Sir William Beveridge, omitted all specific reference to the actual costs and benefits of its program. Congressional reaction to the board's proposals can be gauged by the fact that further appropriations to the board have been refused.

The Social Security Board, in its seventh annual report, was equally vague as to time, cost and benefits. In a section devoted to "extending the social security program," it included only three sentences on hospital benefits.

"The serious aspect of medical costs lies not in the average among the population as a whole but in the unpredictable and heavy burdens of families in which there is a major illness or prolonged illness during a year.

"Provision of benefits to offset the burden of hospital bills on insured workers and their families would be of substantial help in lightening the problem of high-cost illness. The board is of the opinion that the risk of hospital costs is one to which the approach of social insurance is particularly appropriate."

The brevity of this reference coupled with the anti-New Deal attitude of Congress gave rise to belief that no action on this proposal would be taken immediately.

Two other recommendations of the Social Security Board have particular interest for hospitals and, unlike the one just quoted, are in line with the wishes of the majority of hospital administrators as expressed in the A.C.H.A. poll of current issues.

The first is to extend the benefits of the old age and survivors' insurance plan to employes of hospitals and other nonprofit institutions.

The second is to broaden the public assistance program so that it is available for "general" assistance instead of being limited as at present to three special groups (the needy aged, needy blind and children who are dependent because of the death, incapacity or absence of a parent) and to aid the states in financing medical care for recipients of public assistance. Associated with this is a much-needed lowering of residence requirements.

The board also repeated its recommendations for cash benefit payments to persons handicapped by temporary or permanent disability.

Domestic Electric Ranges Put Under New Restrictions

WASHINGTON, D. C.—More specific control of transfers of new domestic electric ranges from remaining manufacturers' and distributors' stocks and complete cessation of production of such ranges are among the new provisions of Order L-23-b as amended March 8.

Manufacture of repair parts is likewise placed under control to make them available through normal trade channels without preference ratings. Clearance for transfer of new electric ranges remaining in manufacturers' or distributors' stocks is made on Form PD-556. There is no change in the requirements for sale from *dealers'* stocks.

Certification of need, as before, must be submitted by the consumer, proving that the old range is worn out or damaged beyond repair or that no other cooking equipment is available and that all internal wiring and power lines for the range service are already installed.

Consumers can procure repair parts under the new procedure without preference ratings from usual trade sources by turning in old parts or certifying that the old parts have been disposed of as salvage.

Under the revised order all production of new electric ranges is prohibited. Only heating units, thermostats, switches, relays, lead-in-wires, connecting wires, handles and hinges can be manufactured.

Illinois Civilian Committee Helps Recruit Student Nurses

Effective help in nurse recruitment was offered to hospital and nursing groups in Illinois with the formation during March of a Civilian War Service Committee with nurse recruitment as its first project.

The committee is headed by Louis Leverone, chairman of the board of the Illinois Chamber of Commerce. Other members of the executive committee include Mrs. Ada R. Crocker, special consultant of the American Red Cross, and Paul Jordan, divisional director of the Office of War Information.

Other cooperating groups include the Illinois Nurses' Association, Illinois Medical Society, Illinois Hospital Association, Rotary, Kiwanis, Illinois Federation of Women's Clubs, American Legion Auxiliary and the Chicago Federated Advertising Club.

A general publicity campaign will be undertaken to enroll 2000 qualified girls to enter nurse training in Illinois during 1943. An effort will also be made to establish scholarships for some of them.

One of the participating organizations, the Rotary Club of Chicago, has already raised a scholarship fund of $1800 which was allocated to 16 student nurses in February entering classes. These students are in accredited Chicago hospitals and are receiving tuition assistance under the federal aid program. The scholarships of $120 per year are for their non-tuition expenditures. The Rotary Club program is under the direction of a committee headed by Stanley R. Clague, president-elect of the club and secretary of The Modern Hospital Publishing Company.

Nursing Routine Simplified

Increasing demands for service and a dwindling nursing staff have caused Rochester General Hospital, Rochester, N. Y., to streamline its nursing routine as far as is compatible with safe practice. Among the recommendations made by the standards committee of the hospital for eliminating nonessential duties were the following: "Three days after admission, or operation, nurses' notes and rectal temperatures will automatically be discontinued on all afebrile patients unless otherwise ordered, individually, by the attending physician. Oral temperatures twice daily (8 a.m. and 4 p.m.) will be substituted upon discontinuing rectal temperatures."

Responsibility of U. S. for Combating Disease Discussed at Conference

Warnings of malaria and influenza outbreaks were brought to the attention of approximately 700 physicians, hospital heads and representatives of the pharmaceutical industry at the National Conference on Planning for War and Postwar Medical Services held in New York City on March 15 under the auspices of the Carlos Finlay Institute of the Americas.

That much of the responsibility for combating the global disease peril during the war and after, in addition to the task of feeding the ravaged countries, will fall upon the United States was the general consensus. To alleviate successfully the sufferings of the world at large and to safeguard our own health require cooperative action on an unprecedented scale.

The fact that the airplane has broken down all normal barriers and that, except for the route to the British Isles, all military air traffic is originating in malarious sections is sufficient reason, according to Dr. Lowell T. Coggeshall, University of Michigan School of Public Health, to expect a malarial epidemic.

That we may be faced with an influenza epidemic comparable to that of 1918 is the opinion of Dr. Thomas Francis Jr., also of the University of Michigan School of Public Health, who indicated that the same elements that prevailed then are present now—overcrowding in defense plants, dislocation of the population and exhaustion from long hours. Also, malnutrition in many lands will increase the danger of the spread of influenza and other diseases.

Dr. John B. Youmans, Vanderbilt University School of Medicine, sees little nutritional disease as a result of war restrictions. This follows similar experience in England. Doctor Youmans urges continued public education of nutrition but warns against playing it up as a panacea for all disease.

Accomplishments in meeting Axis propaganda in South America through the United Americas were described by Nelson A. Rockefeller, Coordinator of Inter-American Affairs. Mr. Rockefeller traced the results of the health work that is going on in which health stations, hospitals and schools are participating and urged the importance of fighting to strengthen our home front.

We shall be faced with a shortage of pharmacists after the war unless a change of policy is effected in Washington, Robert W. Rodman, editor of the *Journal of the American Pharmaceutical Association,* reported. By the end of this year 20,500 of the country's 72,000 active pharmacists will be in uniform with no replacements in sight.

Agencies cooperating in the conference were: American Medical Association, American College of Physicians, American College of Surgeons, American Drug Manufacturers' Association, American Hospital Association, American Pharmaceutical Manufacturers Association, American Pharmaceutical Association, American Surgical Trade Association, Wholesale Surgical Trade Association and the National Physicians' Committee.

"Kentucky Kernels" Makes Bow

"Kentucky Hospital Kernels," a new monthly bulletin for members of the Kentucky Hospital Association, made its appearance in January. It is the hope of the officers of the association that the bulletin "in its humble way may be of some assistance to the association in its efforts to disseminate information, as well as to draw its members into a more closely knit organization."

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War Problems Draw Large Attendance at New England Meeting

Immediate problems involving rationing, manpower and other war restrictions received the major share of attention at the crowded sessions of the New England Hospital Assembly in Boston, March 10 to 12. At the same time it was clearly emphasized that present actions and attitudes will determine the status of hospitals in the postwar period.

Said President James A. Hamilton of the American Hospital Association, "The answer to the future rests with you."

All questions regarding manpower, food, hospital supplies and facilities met the same answer, "We must learn to do without."

According to Everett W. Jones of the War Production Board, only 25 per cent of the steel manufactured this year, 2 per cent of the copper and absolutely none of the aluminum will be available for civilian, including hospital, use this year. Before asking for priorities, Mr. Jones urged, administrators and department heads should ascertain first what they already have. Every crack and corner of existing hospital space in every hospital of the community must be accounted for before there can be any thought of expansion. The cooperation of doctors should also be sought to reduce the length of the patient's stay where possible.

Doctors and nurses will continue to be scarce. Public, physicians and hospitals will have to sacrifice personal conveniences and comply with organizational methods to furnish the 11,000 or 12,000 medical men who must enter the armed services this year. However, we are still better off than others, it was stated by Dr. Frank H. Lahey, chairman of the directing board, Procurement and Assignment Service. In answer to a question from the floor about employing Class B college interns, Doctor Lahey replied, "We have got to cut some corners. I would do it and let the American Medical Association go whistle."

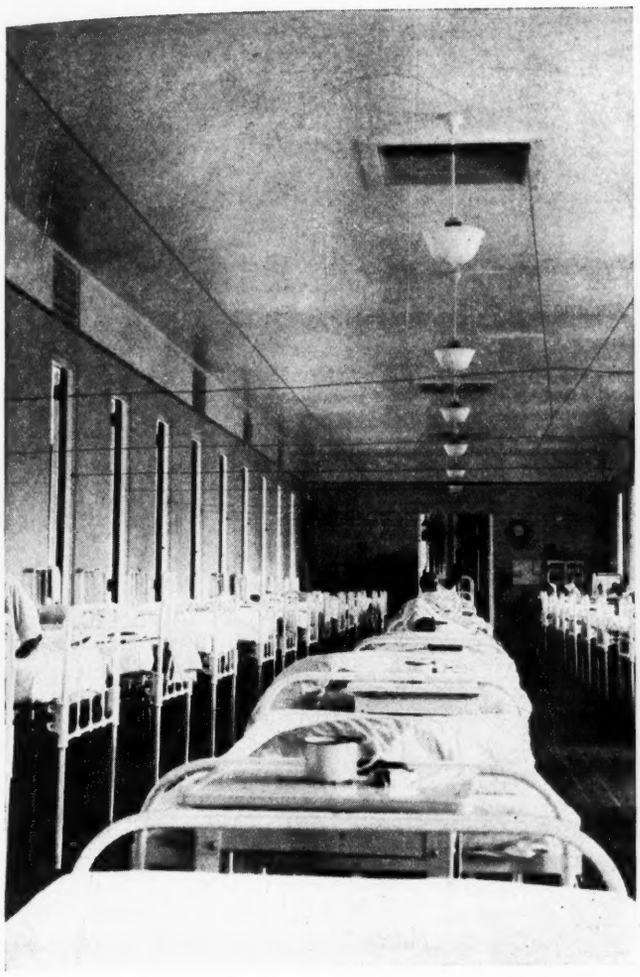
A deficit of 76,000 nurses remains from the estimated total of 290,000 required. The proposed Victory Nurse Corps by which young women entering schools of nursing and the hospitals providing the training would receive assistance from government funds remains in the hands of the budget committee.

Nursing officials, including Marian Sheahan, chairman of the subcommittee on nursing of the Office of Defense Health and Welfare Services, while recognizing the present emergency do not envision the acceleration of nurses' training as comparable to that of doctors because of their shorter vacation period. This does not mean that it cannot or will not be done, however.

Hospitals will be helped by the War Manpower Commission in safeguarding their labor staffs and in recruiting additional workers as needed, but they must be cooperative. Such reassurance voiced by Mary E. Switzer, assistant to the administrator, War Manpower Commission, is significant. She predicted a cut in the labor turnover with the advent of controlled hiring plans and the forty-eight hour week in crowded defense areas.

Voluntary insurance plans, government insurance plans or a combination of the two, which is it to be? The large audience that gathered to hear Dr. Robert H. Bishop Jr., chairman of the Blue Cross committee on approval, American Hospital Association, and Dr. I. S. Falk, director of the bureau of research and statistics, Social Security Board, discuss this subject was left to draw its own conclusions.

Doctor Bishop urged support in the coordination of Blue Cross plans throughout the country and described the progress already accomplished and the prospect of increased enrollment. Doctor Falk, while lauding the good intentions of the voluntary system, emphasized its weakness in failing to reach



MORE HOSPITAL BEDS...MORE FIGHTING MEN

—the promise of 'Sulfasuxidine' succinylsulfathiazole

• 'Sulfasuxidine' succinylsulfathiazole, Sharp & Dohme's new, clinically non-toxic intestinal bacteriostat, shortens hospitalization[1] by contributing to uncomplicated convalescence after abdominal surgery and is also effective in treatment and control of bacillary dysentery,[2] one of the major hazards of military life.[3]

•

This new compound is administered orally for three to five days prior to hospitalization in order to alter the bacterial flora of the intestinal tract and reduce the possibility of peritonitis. Post-operative administration of 'Sulfasuxidine' succinylsulfathiazole contributes to smoother, shorter convalescence.

Bacillary dysentery responds promptly to 'Sulfasuxidine' succinylsulfathiazole at all stages of the disease and carriers also appear to be favorably influenced by the drug.[4]

The remarkably low toxicity of 'Sulfasuxidine' succinylsulfathiazole is partly explained by the fact that the drug is poorly absorbed from the intestinal tract . . . less than 5% is excreted by the kidneys.

'Sulfasuxidine' succinylsulfathiazole is supplied in compressed, 0.5-Gm. tablets, in bottles of 100, 500 and 1,000.
Sharp & Dohme . . . Philadelphia.

'SULFASUXIDINE'

SUCCINYLSULFATHIAZOLE

1. J.A.M.A., 120:265, Sept. 26, 1942. 2. Poth, E.J., and Cheno, B.M., Jr., Knotts, F.L., Journal of Lab. and Clin. Med., 28:162, Nov., 1942. 3. New York State J. Med., 42:789, April 15, 1942. 4. J.A.M.A., 119:615, June 20, 1942.

the large part of the population. "It is not the aim of social security in this country to meet all contingencies," Doctor Falk stated, "but to assure the people, especially families, at least a minimum basic protection against ordinary risks."

Later in the day the audience responded enthusiastically to President Hamilton's challenge that it was not minimum but maximum protection to the health of the nation that counted and that dollar for dollar the wage earner will not receive under government control the quality of protection he gets under the present voluntary system.

To help meet the complexities of the food price situation, Edward Stiller, institutional representative, Food Rationing Section, O.P.A., Boston, urged hospital executives to establish personal contacts with their local boards and not to hesitate to make known to them any critical emergencies. Among other suggestions he advocated checking back with the dietitian; using more fresh foods; checking on refrigerators, especially the humidity result of the coil; preparing menus to meet daily marketing conditions; using more auxiliary help, and controlling waste.

Officers elected for the new year are President, Frances C. Ladd, Faulkner Hospital, Jamaica Plain, Mass.; vice president, Oliver G. Pratt, Salem Hospital, Salem, Mass.; treasurer, Donald S. Smith, Mary Hitchcock Memorial Hospital, Hanover, N. H., and secretary, Gerhard Hartman, Newton Hospital, Newton Lower Falls, Mass.

California Conference Discusses Blue Cross Plans; War Problems

Blue Cross plans were discussed at length at the war conference of the Association of California Hospitals held in Berkeley on February 24 and 25. After a talk on "National Trends in Blue Cross Plans," by James A. Hamilton, president of the A.H.A., a round table was held on the subject "Are We Meeting the Demands?" As a result of this discussion a resolution was passed by the association urging that steps be taken toward the merger of existing California Blue Cross plans in order to serve the public more effectively.

Other highlights of the conference were the talks on the priority program by Everett W. Jones and on food rationing by Guy R. Kinsley, regional food rationing representative of O.P.A. It was the general consensus that these discussions clarified a good many questions in the minds of administrators and trustees.

A symposium on the administrative aspects of the Kenny treatment of poliomyelitis was held at the Wednesday morning session, which concluded with a color film demonstrating the results obtained by this treatment.

Dr. Clifford W. Mack, Livermore Sanitarium, Livermore, was inducted as president for the ensuing year and Walter Mezger, Cedars of Lebanon Hospital, Los Angeles, was named president-elect.

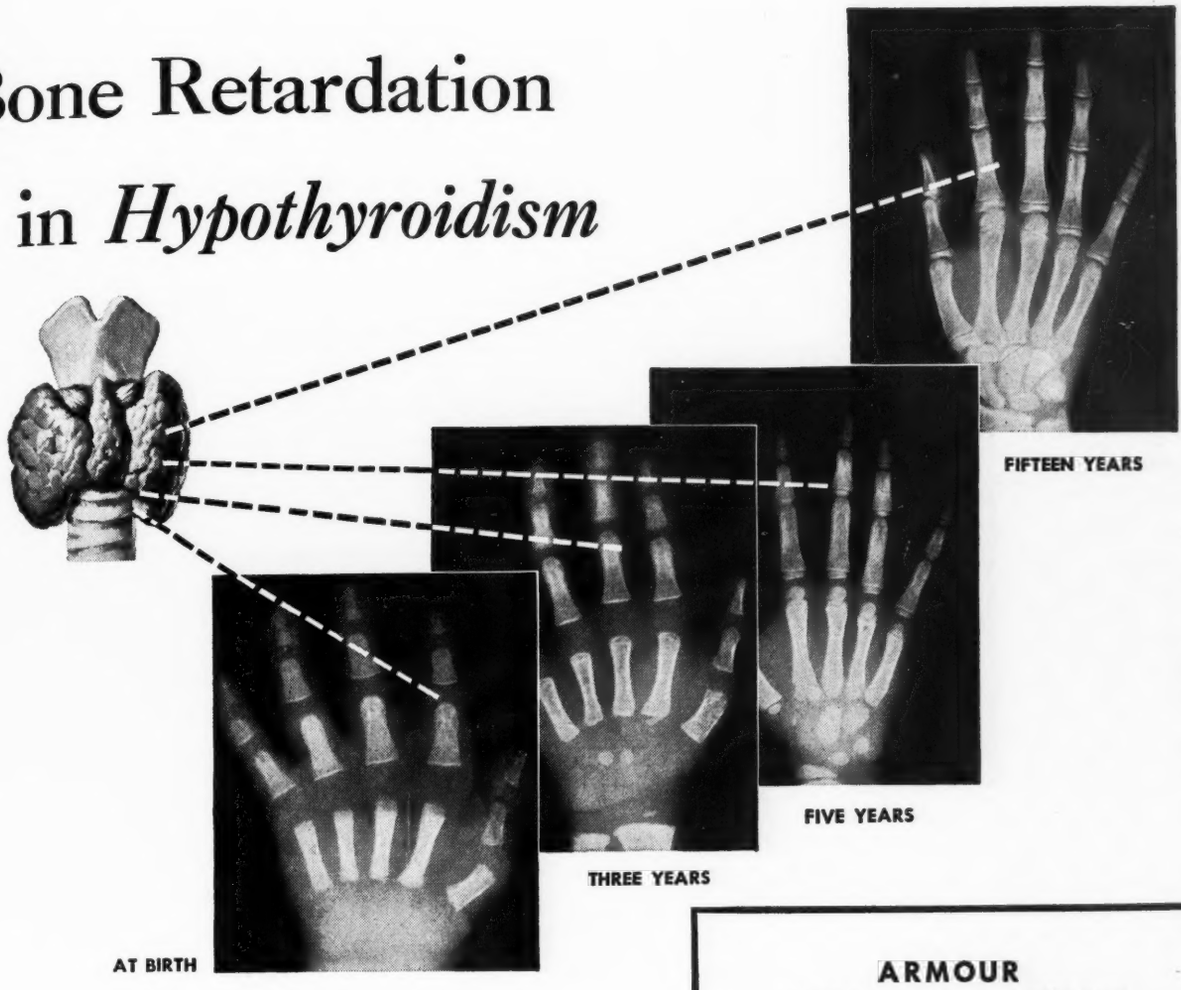
Guide to Facilities for Cripples

Information concerning hospital and convalescent facilities for crippled children is contained in the directory recently published by the National Society for Crippled Children, Inc., whose annual sale of Easter seals will be held this year from March 26 until Easter. It is felt that the book will be particularly useful to public health nurses, hospital staffs, social workers and others interested in the care of crippled children.

Urological Meeting Canceled

In view of the government's request that conventions be cut to a minimum, plans for the June meeting of the American Urological Association in St. Louis have been canceled. Officials of the association have also announced that the $500 research prize offered annually will not be awarded this year.

Bone Retardation in *Hypothyroidism*



ENGELBACH and others have emphasized the importance of a study of bone development in the diagnosis of hypothyroidism, since in this condition the bone age tends to lag behind the chronologic age.

Once the diagnosis is established, uniformity and standardization of the thyroid medication are of paramount importance in mild as well as in severe cases.

From the very earliest days of thyroid therapy Armour has spared no efforts in producing thyroid preparations of dependable, unvarying potency. Armour scientists were first to recognize and institute methods for overcoming the regional and seasonal variation in animal thyroid. In the preparation of THYROID *Armour* today, the selected glands are chosen carefully by geographic areas where a relatively stable proportion exists between thyroxin and the other organic iodine compounds. The desiccated glands are assayed and then blended to fixed standards — a method also devised by The Armour Laboratories, and made possible by Armour's tremendous supply of raw material. It is sound practice to specify "Armour" whenever ordering thyroid.

Specify THYROID ARMOUR

Thyroid Armour is supplied in 1/10, 1/4, 1/2, 1, 2, and 5 grain tablets — either plain or enteric coated, and in powder.

ARMOUR LIVER PREPARATIONS

In the manufacture of liver preparations as in thyroid preparations, The ARMOUR LABORATORIES has available the world's largest supply of fresh raw material. Therefore it is possible to employ only the carefully selected livers of young, healthy, actively growing animals in the manufacture of Armour liver preparations. Armour scientists and technicians are skilled in judging, handling and processing of animal products. These are some of the reasons why the name "ARMOUR" has come to stand for "excellence" in liver preparations.

Liver Liquid (Parenteral) Armour

4 U. S. P. Units (injectable) per cc. in 1 cc., 5 cc., and 10 cc. rubber-capped vials.

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Solution Liver Extract (Oral) Armour

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Founding of Women's Council Announced at Texas Hospital Meeting

The organization of the Presidents' Council of the Women's Auxiliaries of Dallas Hospitals was announced at the meeting of the Texas Hospital Association in Fort Worth on February 18 and 19 by Mrs. Gillespie Kribs, Southern Methodist University.

This war conference, which had no commercial exhibits, was attended by more than 400 hospital administrators, records librarians, nurse anesthetists, accountants and guests.

The presidents' council is composed of the current presidents of each of the 10 hospital women's auxiliaries in Dallas. Meetings are held twice a year for the discussion of common problems and the council is also represented in the Dallas County Hospital Council. The Texas Hospital Association voted to invite members of women's auxiliaries to become members of the association and to conduct a section meeting at the next annual convention.

The $110,000 deficit of the Blue Cross Plan of Texas was transformed into a $35,000 surplus at the end of 1942, according to a report made by W. R. McBee, administrator, covering the eighteen months since the reorganization of the plan.

Federal officials explained food rationing, emergency medical service, the nurses' aide program and the federal program for nursing education.

Smaller hospitals were urged by Jane E. Taylor, associate nursing education consultant, U.S.P.H.S., to organize central schools of nursing in communities in which there is at least one hospital with a daily average of 100 patients or more to increase the clinical experience of students and increase enrollment.

A. C. Seawell of City-County Hospital, Fort Worth, succeeds Margaret Hales Rose of Wichita General Hospital, Wichita Falls, as president. New officers are: president-elect, Eva M. Wallace, All Saints Hospital, Fort Worth; vice presidents, Sister Antonia, St. Paul's Hospital, Dallas, M. LaCoke Jastrow, Medical Arts Hospital, San Antonio, and Clara E. Burke, Nightingale Hospital, El Campo; treasurer, B. T. Terrell, Harris Memorial Methodist Hospital, Fort Worth.

Hospitals Warned Against Impersonator of Baseball Star

Hospitals are warned to be on the lookout for a swindler who has been impersonating Vann L. Mungo, pitcher for the New York Giants. On three occasions this man has entered southern hospitals, two in Washington, D. C., and one in Greenville, S. C., complaining of a kidney ailment and has signed checks in payment of his bill, which were subsequently returned as being worthless.

The man is 6 feet 3 or 4 inches tall, weighs approximately 240 pounds and is apparently thoroughly familiar with the events of the real Mr. Mungo's life.

R. B. Eleazer, Jr., assistant superintendent of Greenville General Hospital, in a letter to The Modern Hospital urged that hospitals demand full identification of this man before accepting him as a patient. Any information concerning him should be relayed to Vann L. Mungo, Pageland, S. C., who is extremely anxious to apprehend his impersonator.

Waves Needed for Hospital Corps

The procurement of 5800 Waves to serve in the hospital corps has been requested by the Surgeon General of the Navy. Wave members of the Navy hospital corps are enlisted as apprentice seamen and then undergo a routine period of indoctrination, following which they are transferred to naval hospitals for duty. In addition, 38 yeomen Waves have been requested for assignment to the Bureau of Medicine and Surgery as replacements of hospital corpsmen.

From *tests* springs the certain proof of safety . . . thorough, complete, and costly tests which only a specialized, scientifically equipped laboratory is qualified to make . . . tests far beyond the capacities of the average hospital, and too expensive and time-consuming for practicability in even the largest institutions. At Baxter, where the one task is to produce solutions and accessories for *safe* intravenous therapy, such essential tests are routine —the chemical, bacteriological, biological verifications which alone can prove the purity, sterility, and pyrogen-free qualities of every liter of intravenous solution produced in the four Baxter Laboratories. The assurance of safety guaranteed by these Baxter tests— 21 tests and inspections ranging from qualitative and quantitative chemical analyses to biological tests with laboratory animals—is a major contribution to the confidence of the doctor and the hospital in the safety of their intravenous therapy.

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Fund Drives for Two Connecticut Hospitals Receive Large Donations

Reports on fund-raising projects for two Connecticut hospitals reveal that contributions to both have been unprecedentedly large.

In Bridgeport, the drive conducted by the United Hospital Building Fund at Bridgeport, Conn., for $750,000 to improve and enlarge the city's two voluntary hospitals, Bridgeport and St. Vincent's, was surpassed by nearly a quarter of a million dollars.

The campaign, which was begun in July 1942, came to an end with a final report dinner on February 23. The grand total of funds raised was reported as $986,050.

The campaign being conducted in Hartford for the sum of $5,000,000 with which to finance a program that virtually projects the replacement of the present Hartford Hospital has achieved "spectacular" results in recent months, according to Will, Folsom and Smith, financial campaign house. Hartford Hospital, the largest voluntary institution in the United States, was operating at 81 per cent of its theoretical capacity in 1938. By 1941 this utilization had risen to an average of 96 per cent.

Texas Hospitals Prove the Practicability of "Swap or Sell" Program

Texas hospitals have undertaken a "help-your-neighbor" program of exchanging or selling various items of equipment. Reports of the council on construction and plant operation of the Texas Hospital Association indicate that the program has proved quite successful.

In order to obtain data on available equipment, a check list of general items utilized in all hospital departmental functions involving equipment that is under priority regulations was sent to all Texas hospitals and clinics listed by the American Medical Association. When each institution had checked items that it was willing to exchange or sell, the list was returned to the council chairman for tabulation.

After the tabulation had been completed, the list of available articles, including the name and location of the hospitals that possessed them, was distributed to all institutions that had received the original list of equipment.

Proof of the practicality of the program was evidenced at the annual meeting of the association at which groups of hospital administrators got together over the lists to consummate deals.

Vital War Problems to Feature Tri-State Hospital Program

With the theme, "Vision Is Vital for Victory," the annual Tri-State Hospital Assembly will open at the Palmer House, Chicago, on May 5 for three days of intensive consideration of wartime problems.

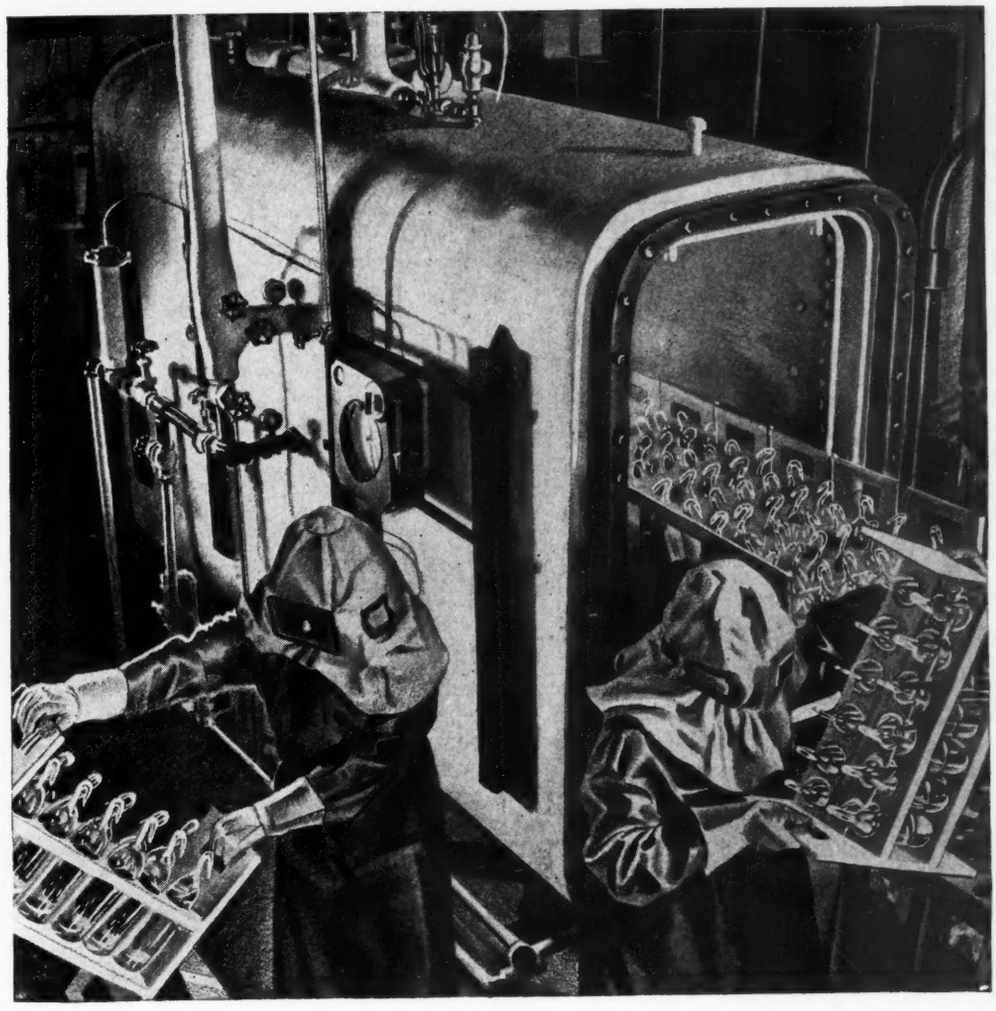
According to preliminary plans announced by Dr. Malcolm T. MacEachern, chairman, the general subjects for the three morning war-time assemblies will be as follows: "Civilian Defense," "Personnel Problems" and "Furnishings, Equipment and Supplies."

The exhibits will provide visual education on how to meet problems of priorities, rationing, substitutions and conservation.

Governmental agencies will be drawn upon for speakers. Authorities from military and civilian services, prominent physicians, heads of nursing organizations and others will be available for direct consultation.

"Homes Quarterly" Published

A quarterly magazine dealing with problems of homes for the aged made its first appearance in February under the sponsorship of the Illinois Homes for the Aged. Entitled *Illinois Homes Quarterly,* the publication is designed to provide member homes and their executives a medium for the exchange of ideas.



TRIAL BY FIRE

IN the Middle Ages, the accused was sometimes subjected to "trial by fire." If he withstood the ordeal, he proved himself innocent and was then set free.

Similarly, a number of severely exacting tests are given Solutions in Sterisol Ampoules before they can be released for intravenous use. One of these tests is a veritable "trial by fire." Following autoclaving at 240 degrees, the ampoules are plunged immediately into cold water. Only the finest dispensing container, positively sealed, can survive such a gruelling ordeal.

And the Sterisol Ampoule is such a dispensing container: Made entirely of Pyrex, each ampoule is sealed hermetically by fusion of the glass. Sterisol Ampoules assure safety and security at all times. Nothing but glass can touch the solution until the instant of use in the hospital.

Dextrose and Saline Solutions in all concentrations usually required by hospitals are available in Sterisol Ampoules. Economy and uniformity are assured by quantity manufacture. Solutions are chemically correct, proved sterile and physiologically tested for pyrogens. Freedom from reaction-provoking impurities can be depended upon. Three convenient sizes—1,000 cc., 500 cc., 250 cc. For literature on Sterisol Ampoules, write to Schering & Glatz, Inc.—Sterisol Division.

SCHERING & GLATZ, INC., 113 WEST 18th STREET, NEW YORK CITY

Hospitals Get AA-1 Rating for Maintenance and Repairs

(*Continued from page* 49)

Governmental or nonprofit public dispensaries, clinics and health stations and educational institutions are given a preference rating of AA-2X.

The Controlled Materials Plan to which this new regulation applies covers steel, copper and aluminum in their raw states and in many finished forms.

In interpreting the significance of this new order, Everett W. Jones, head hospital consultant of the W.P.B., stated that "hospitals enjoy a real privilege under this new order and must not abuse it. They can cooperate by not using the AA-1 rating until every effort has been made to obtain delivery from wholesalers, retailers or distributors without any rating or using the A-10 rating.

"The valuable AA-1 rating must not be used unless it is impossible, after really trying from all possible sources of supply, to get delivery without it. Abuse of the high rating will lessen its value. It should not be used merely because one or two dealers ask for it. Overuse or abuse of the rating may well lead to revocation of the new order which we have worked so hard to get."

Larger Food Allowance May Be Allotted to Hospitals

WASHINGTON, D. C.—At a meeting of regional O.P.A. food rationing directors held in Washington on March 15 and 16, special instructions were given that hospital applications for supplemental rations must be handled promptly and liberally. Hospital superintendents may sign the requests for supplemental rations. All between-meal nourishments can be counted as "meals."

A plan is under consideration concerning the handling of the ration books of patients.

Protests on hospital food rationing were voiced on March 18 by various New York City hospitals and institutions which requested an increase in the points allotted to hospitals.

President Hamilton and Dr. Claude Munger appealed to hospitals and associations not to increase the work in the food rationing division by further protests. "Be patient for a short time; it is expected that more satisfactory policies will soon be adopted," they said on March 23.

MacLean Given Commission

Dr. Basil C. MacLean, director of Strong Memorial Hospital, Rochester, N. Y., has been commissioned a lieutenant colonel in the U. S. Army Medical Corps on special assignment to study all military hospitals to determine whether the nation's military medical personnel is being used to best advantage. He will be on leave of absence for the duration. Doctor MacLean is one of the "few physicians I have personally requested to enter the service," Maj.-Gen. James C. Magee stated.

Institute on Prepayment Plans to Open in Ann Arbor May 10

Training in the organization and management of various types of prepayment plans will be offered at a two weeks' institute to be held at the University of Michigan School of Public Health starting May 10. Made possible by a Rockefeller Foundation grant, through the Committee on Research in Medical Economics, the institute will meet the needs of two types of students.

These include persons already working with a prepayment plan or having a specialized interest in this field of administration and those who are concerned with public health, hospital administration or other community services and who wish to learn about the field of health service plans.

A registration fee of $5 will be charged for the course and students may live on the campus at moderate rates. Full information is available from Nathan Sinai, Dr. P.H., University of Michigan.

Premedical Freshmen Deferred

Preprofessional students in medicine and dentistry are included in the directive issued by the Selective Service headquarters on March 3 deferring college freshmen majoring in the sciences from the draft. The order ruled that all students in engineering, pure sciences and courses required for entrance to medical and dental schools who will complete their work before July 1, 1945, should be granted deferments until that date. The new directive will have no effect upon the programs of freshmen or other students who are already members of the enlisted reserve.

Coming Meetings

April 15-16—Hospital Association of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia.
April 27-29—Ohio Hospital Association, Neil House, Columbus.
May 5-7—Tri-State Hospital Association, Palmer House, Chicago.
May 6-8—Carolinas-Virginias Hospital Conference, Roanoke, Va.
May 10—Mississippi State Hospital Association, Heidelberg Hotel, Jackson.
May 23-25—Minnesota Hospital Association, Nicollet Hotel, Minneapolis.
May 26-28—New York and New Jersey Hospital Association, Hotel Pennsylvania, New York City.
June 12-14—Catholic Hospital Association, William Penn Hotel, Pittsburgh.
June 15-17—National League of Nursing Education, Chicago.
Oct. 12-14—American Public Health Association, New York City.

NAMES IN THE NEWS

Administrators

J. Harvey Jennett, M.D., has been appointed medical director of the University of Kansas Hospitals, Kansas City, Kan.

Ruth Allene Mercer is acting administrator of University Hospital of the School of Tropical Medicine, San Juan, Puerto Rico.

H. P. Glendinning succeeds **A. R. Hazzard** as administrator of Chestnut Hill Hospital, Philadelphia. Mr. Glendinning was formerly a trustee of the hospital.

Mrs. Mary C. Crerdon, R.N., is the new superintendent of Community Hospital, Geneva, Ohio.

May H. Rohr has accepted the position of superintendent of Clinton Memorial Hospital, St. Johns, Mich.

L. H. Carson has been appointed superintendent of Morehead City Hospital, Morehead, N. C.

Ruth Guinn has been appointed superintendent at St. Elizabeth Hospital, Elizabethton, Tenn.

Wilma Ashby recently assumed the duties of superintendent of Northampton Accomac Memorial Hospital, Nassawadox, Va.

Melissa M. Dailey, R.N., is the new superintendent of the Toledo Society for Crippled Children, Toledo, Ohio. She was formerly superintendent of the Samaritan Hospital in Ashland, Ohio.

R. H. Duncan has accepted the post of administrator of Carle Memorial Hospital, Urbana, Ill.

Mrs. Gatzke Nelson has been appointed superintendent of Finley Hospital, Dubuque, Iowa.

Bernetta Heinzen, R.N., has assumed the superintendency of the West Central Minnesota Hospital, Graceville, Minn.

E. P. Street is the new administrator of Children's Hospital, Philadelphia, succeeding **Susan C. Francis. M. M. Ingersoll** is superintendent of nurses.

Lillian N. Ganere is superintendent of Rocky Mount Sanitarium, Rocky Mount, N. C.

E. McNary has been appointed superintendent of Behrens Spa, Waukesha, Wis.

Edith Atkin, formerly superintendent of Amsterdam City Hospital, Amsterdam, N. Y., recently succeeded **Clara B. Peck** as administrator of the House of Mercy Hospital, Pittsfield, Mass. Miss Peck resigned.

Darius Caffaratti, M.D., has been made superintendent of Butte County Hospital, Oroville, Calif. Formerly the resident physician, he succeeds **Archie J. Allen,** now in charge of buildings and supplies.

Lela E. Booker is the new director of the Institute of Nutrition, Milwaukee Children's Hospital, Milwaukee, Wis.

Matthew J. Noon, M.D., former field consultant and clinic physician for the Wisconsin Anti-Tuberculosis Association at Milwaukee, has been appointed superintendent of the Kansas City Municipal Tuberculosis Hospital, Kansas City, Mo. He succeeds **Oscar C. Heyer, M.D.,** who resigned to do tuberculosis work in Illinois.

Lt.-Col. Curtis H. Lohr, superintendent of the St. Louis County Hospital, St. Louis, and executive officer of the 70th General Army Hospital, is awaiting orders from the Army.

Morris Roth, formerly assistant superintendent of the Brooklyn Hebrew Home and Hospital for the Aged, Brooklyn, N. Y., is the new executive director of the Haym Salomon Home for the Aged, New York City.

Eva Y. Gladue has resigned as acting superintendent of J. C. Blair Memorial Hospital, Huntingdon, Pa., to join the Army Nurse Corps.

David R. Kennerson has accepted the position of administrator at Clearfield Hospital, Clearfield, Pa.

Dare E. Marriott has recently assumed the duties of business manager of Renton Hospital, a newly proposed government institution of 100 beds to be built near Seattle.

John H. Zenger has taken over the duties of superintendent of Utah Valley Hospital, Provo, Utah., succeeding **Mildred Walker,** who resigned to join the Waacs.

Helen Blithe, R.N., has been named superintendent of the new hospital at the Montgomery County Institution District Home at Royersford, Pa.

Edna M. Witmer, R.N., has resigned as superintendent of the Soldiers and Sailors Memorial Hospital, Wellsboro, Pa. **B. Clifford Woolsey,** formerly manager of the Tioga County office of the United States Employment Service, has been appointed business manager.

H. A. Burns, M.D., formerly in charge of the Minnesota State Sanatorium at Ah-Gwah-Ching, Minn., is now in charge of tuberculosis problems for all Minnesota state institutions. Succeeding Doctor Burns at the state sanatorium is **Dr. F. F. Callahan,** who recently resigned her position as head of the Pokegama Hospital at Pokegama, Minn.

T. Truxton Hare has been named managing director of Bryn Mawr Hospital, Bryn Mawr, Pa. He succeeds his brother, **Charles Willing Hare,** who died last December.

Charles Wollenberg, superintendent of Laguna Honda Home, San Francisco, celebrated his seventieth birthday on March 15 and announced his retirement effective April 1. During the San Francisco fire and earthquake of April 18, 1906, Mr. Wollenberg, then a pharmacist, did such outstanding rescue work that he was put in charge of a hospital for rehabilitation of the victims.

Department Heads

Mrs. Marie Linder has resigned as superintendent of nurses at Evangelical Deaconess Hospital, Lincoln, Ill.

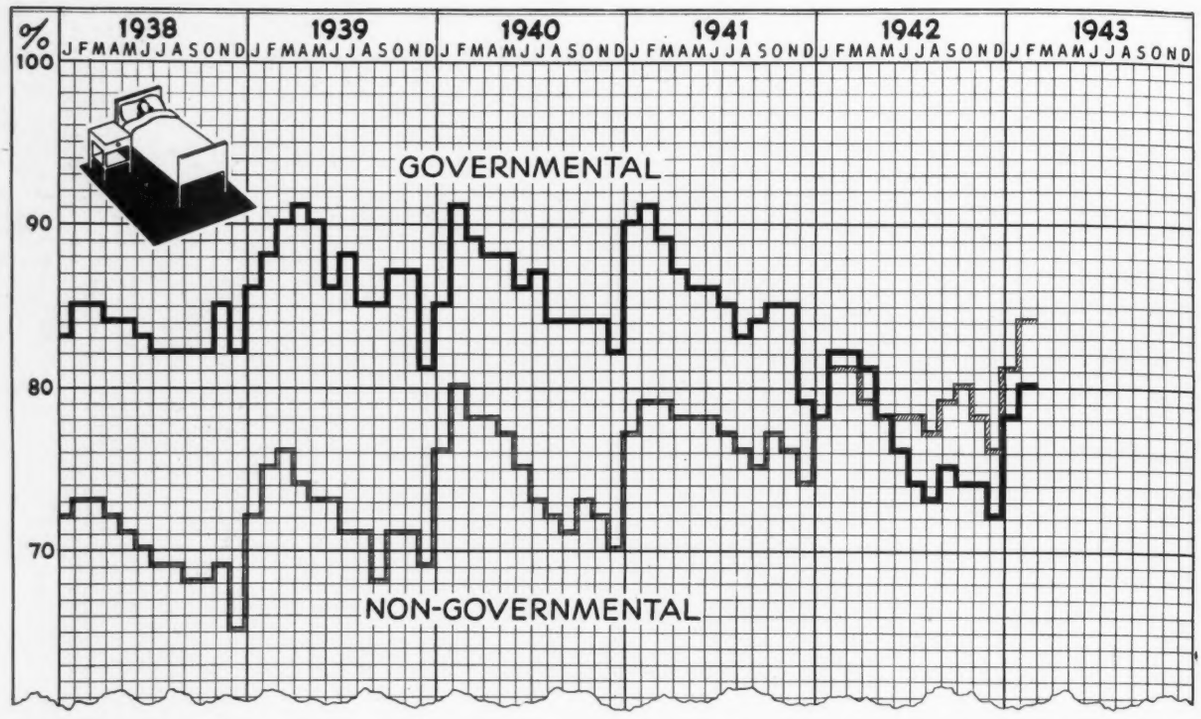
Annie E. Grass, director of nursing, Grasslands Hospital, Valhalla, N. Y., since 1930, has retired from active service. She is succeeded by **Mrs. Almira Hoppe Hemstead,** formerly associate director of nursing at Albany Hospital, Albany, N. Y.

Miscellaneous

Ethel Johns, editor and business manager of The *Canadian Nurse,* has resigned her position. The resignation will be effective December 31. **Jean S. Wilson, R.N.,** has announced her resignation as executive secretary of the Canadian Nurses Association, to take effect September 30.

Col. Charles F. Shook, formerly with the services of supply, office of the surgeon general of the Army, has been appointed special representative of the surgeon general for the blood plasma program for the armed forces.

All Occupancy Records Shattered in February



The highest occupancy ever recorded for voluntary general hospitals was reflected in the tentative report of 84 per cent for February. New Orleans and St. Paul reported occupancies of more than 90 per cent. San Francisco, Chicago and Cleveland were above 80 per cent.

Twenty-seven new hospital construction projects, announced between February 22 and March 22, with a total value of $17,029,960 brought the year-to-date total to $37,831,381 as compared to $30,628,458 last year. Projects deferred this year total $14,972,500. Comparable figures are not available for last year.